Rural Health Clinics of Washington Study

Presented today by:
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Larry Thompson, East West Consulting
Charlotte Hardt, Eastern Washington AHEC
Terry Tatko, Western Washington AHEC

PRESENTATION OVERVIEW

- Purpose of the RHC Study—Alice James, DOH/OCRH
  - Methodology
  - Collaboration with stakeholders
  - Objectives for Today
    - Learn about WA State RHC profile, financial, qualitative information
    - Discussion on study findings, recommendations, next steps
- Profile of RHCs in WA State

PRESENTATION OVERVIEW

- Financial information for RHC in WA State
- Qualitative information for RHC in WA State
- Break
- Findings and Preliminary Recommendations
- Group Questions and Discussion
  - Questions
  - Other suggested recommendations
  - Next Steps

PURPOSE OF THE STUDY

- Objective and comprehensive profile of Medicare Certified Rural Health Clinics (RHC) in Washington State
- Role of RHCs in the *Safety Net*
- Tool for RHCs to use to improve efficiency and effectiveness
- Information for Rural Health Clinic Association to use for training and technical assistance
- Information for Policy Makers

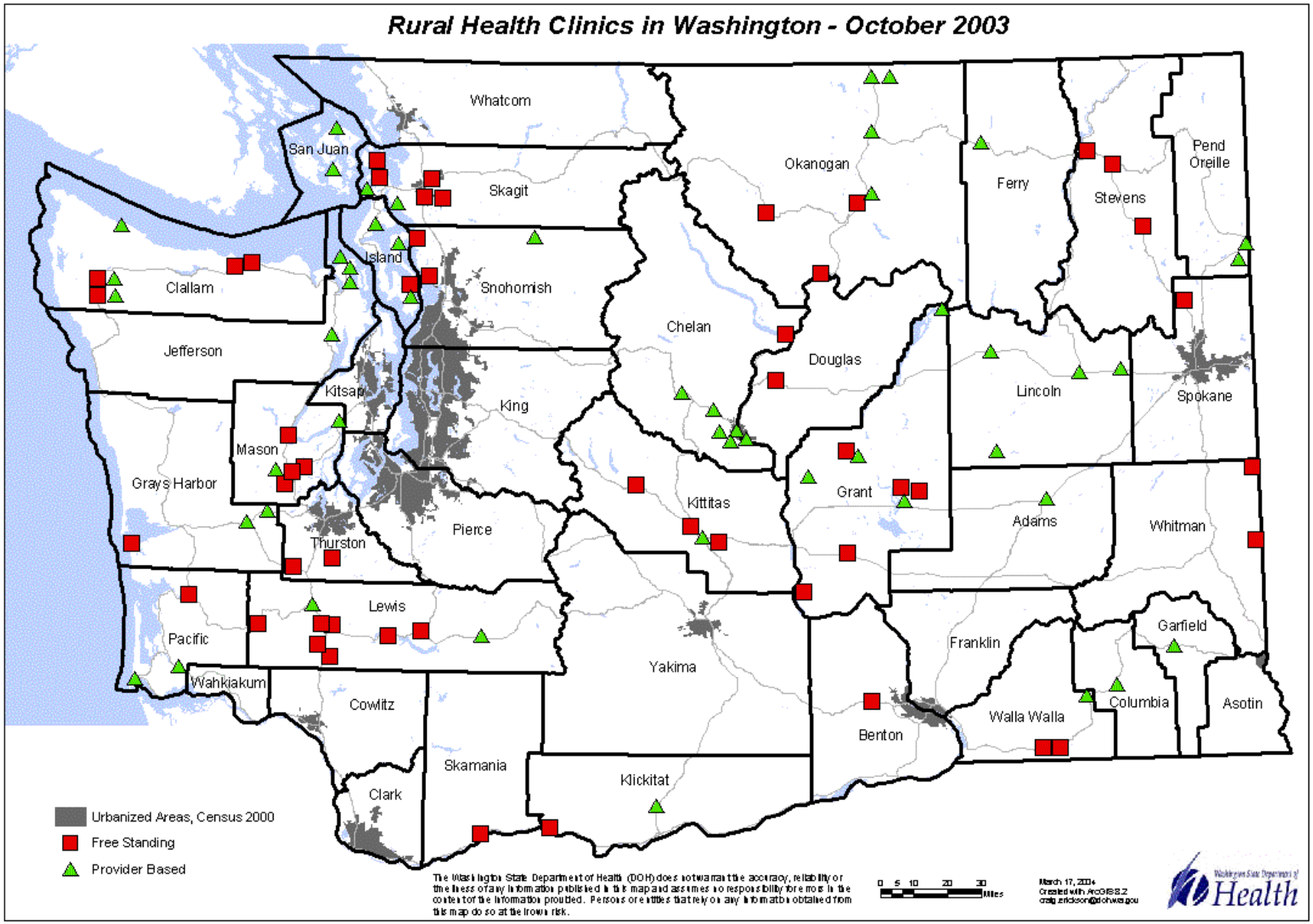
STUDY METHODOLOGY

- Collaboration with Rural Health Clinic Association of Washington and others
- Site visits for collection of qualitative data
- Submission of financial data by clinics
- Study team composed of WA State Office of Rural Health, WW AHEC, EW AHEC, East West Consulting
- Funding provided by Federal Office of Rural Health Policy
- Two year duration

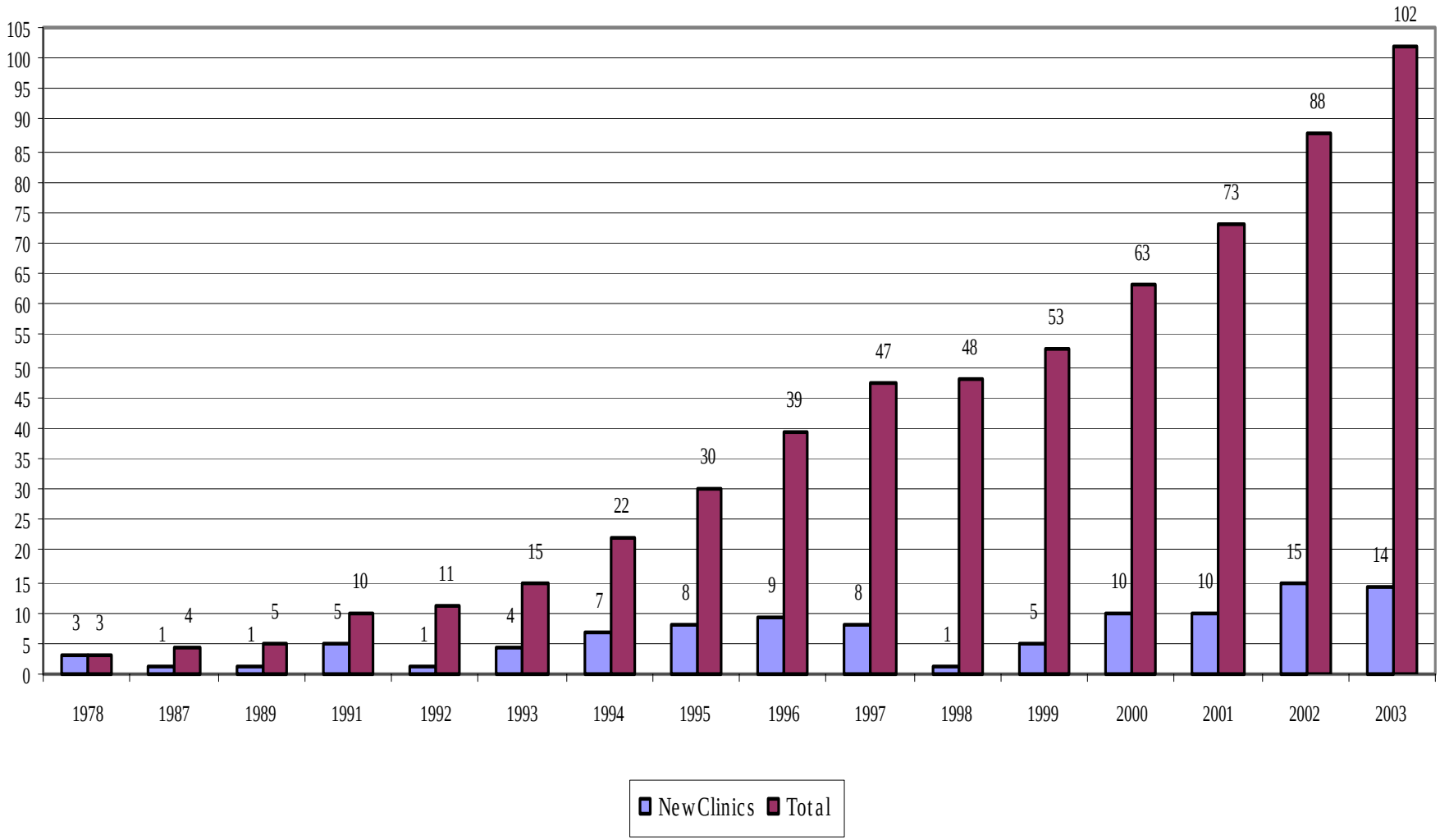
Profile of Rural Health Clinics

- All certified RHCs in Washington State as of 8/03
- Interviewers
  - WWAHEC – Laurie Wylie, Jodi Palmer, Terry Tatko
  - EWAHEC – Steven Meltzer, Cathi Lamoreux, Charlotte Hardt
- Interviews conducted Summer of 2003
- *n* = *88* out of 102 possible in Qualitative Study
  - Western WA 46 of 52*
  - Eastern WA 42 of 50*

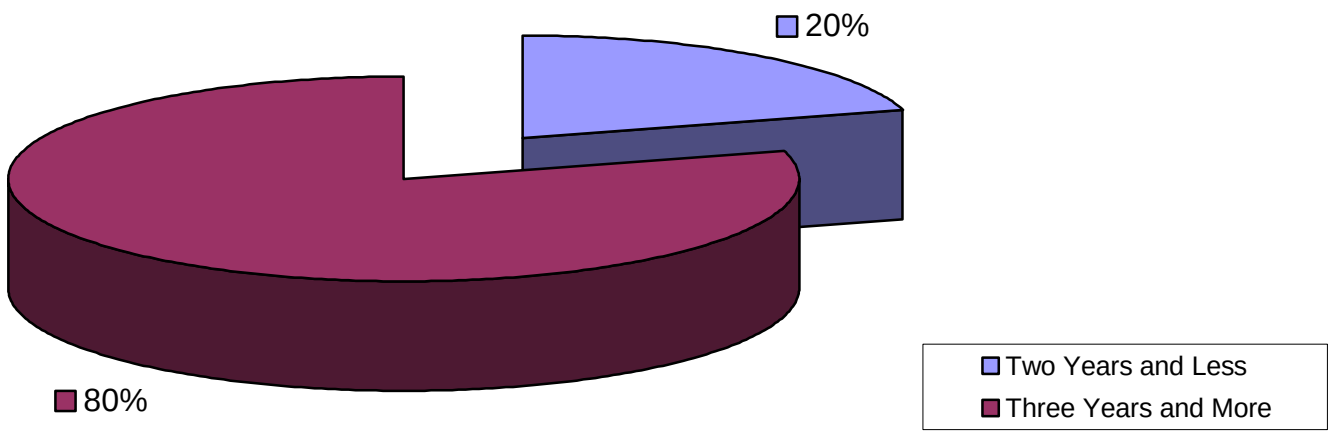
**Provided some information*


Rural Health Clinics in Washington - October 2003
Whatcom
San Juan
Skagit
Island
Snohomish
Clallam
Jefferson
Kitsap
King
Mason
Gray's Harbor
Thurston
Pierce
Lewis
Pacific
Wahkiakum
Cowlitz
Skamania
Clark
Okanogan
Ferry
Stevens
Pend Oreille
Chelan
Douglas
Lincoln
Spokane
Kittitas
Grant
Adams
Whitman
Yakima
Franklin
Garfield
Benton
Walla Walla
Columbia
Asotin
Klickitat
Urbanized Areas, Census 2000
Free Standing
Provider Based
The Washington State Department of Health (DOH) does not warrant the accuracy, reliability or timeliness of any information published in this map and assumes no responsibility for errors in the content of the information provided. Persons or entities that rely on any information obtained from this map do so at their own risk.
0 5 10 20 30
Miles
March 17, 2004
Created with ArcGIS 8.2
craig.erickson@doh.wa.gov
Health

Rural Health Clinics in Washington state by Date of Certification



Years as a RHC



RUCA Codes Used

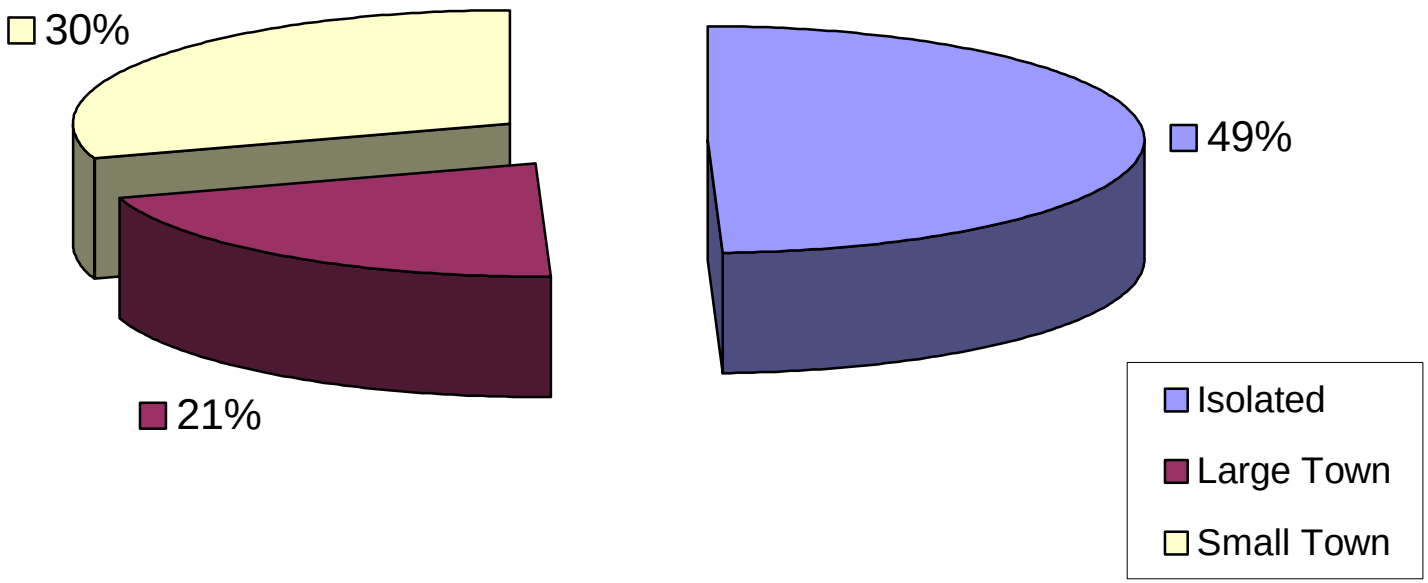
- The location of RHCs was classified using Rural Urban Commuting Area (RUCA) codes. Usually a 10 category classification, for this initiative they have been consolidated to a three-level category to identify the geographic variables.

  Large town core areas (between 10,000 and 50,000)

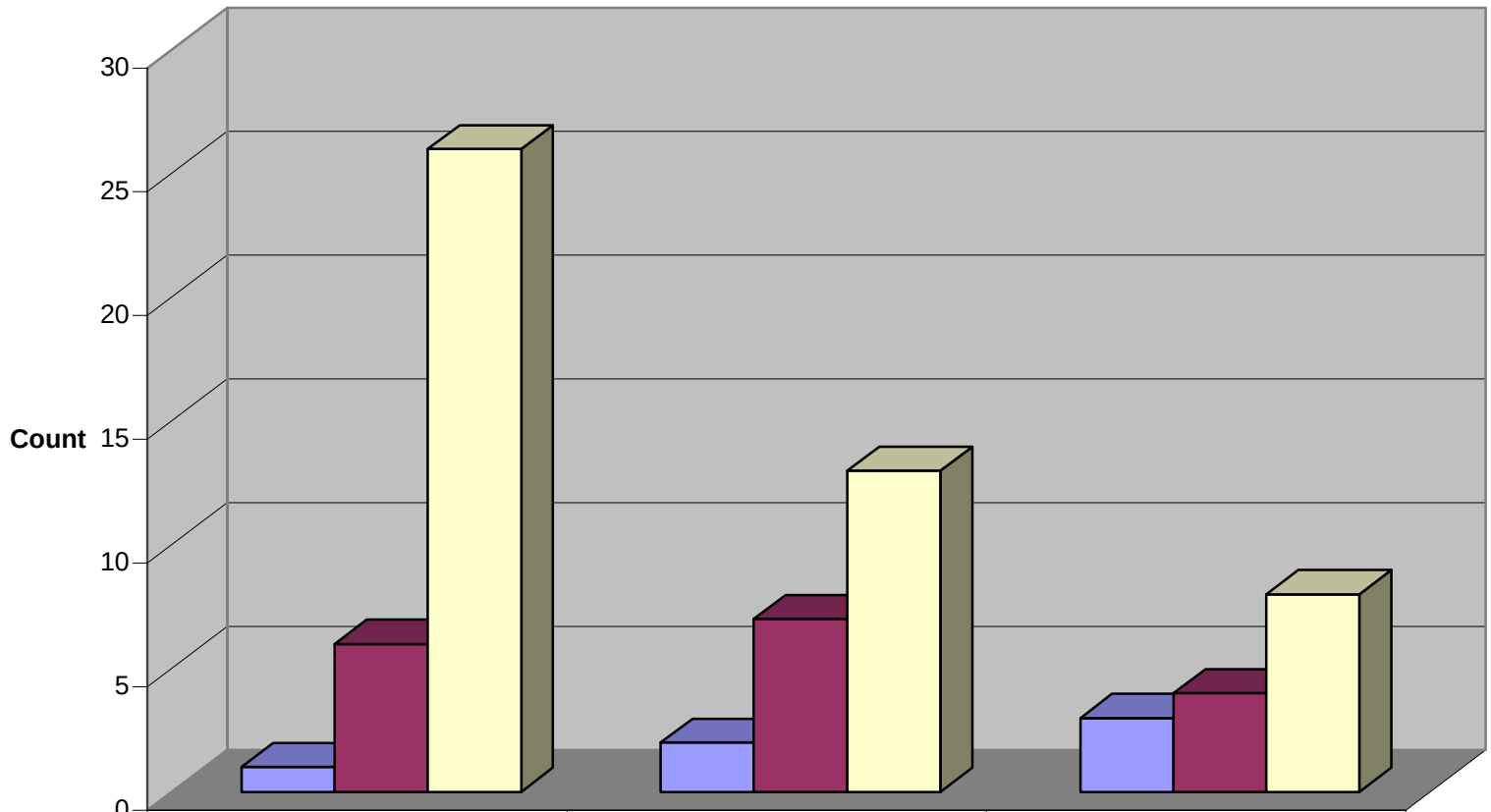
  Small town core areas (between 2,500 and 10,000)

  Isolated rural areas (towns of less than 2,500)

RUCA Code Distribution

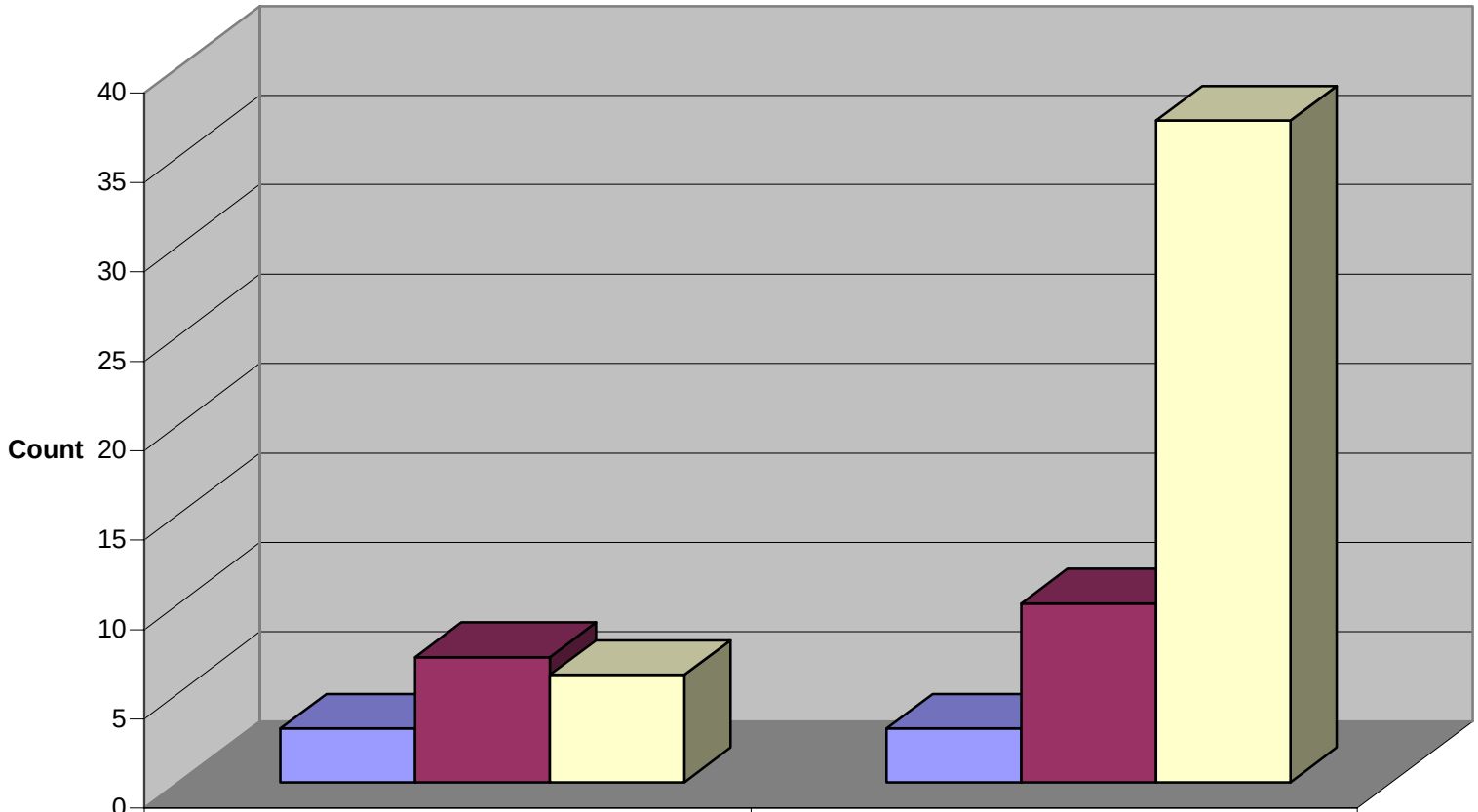


Type of Clinic by RUCA Code



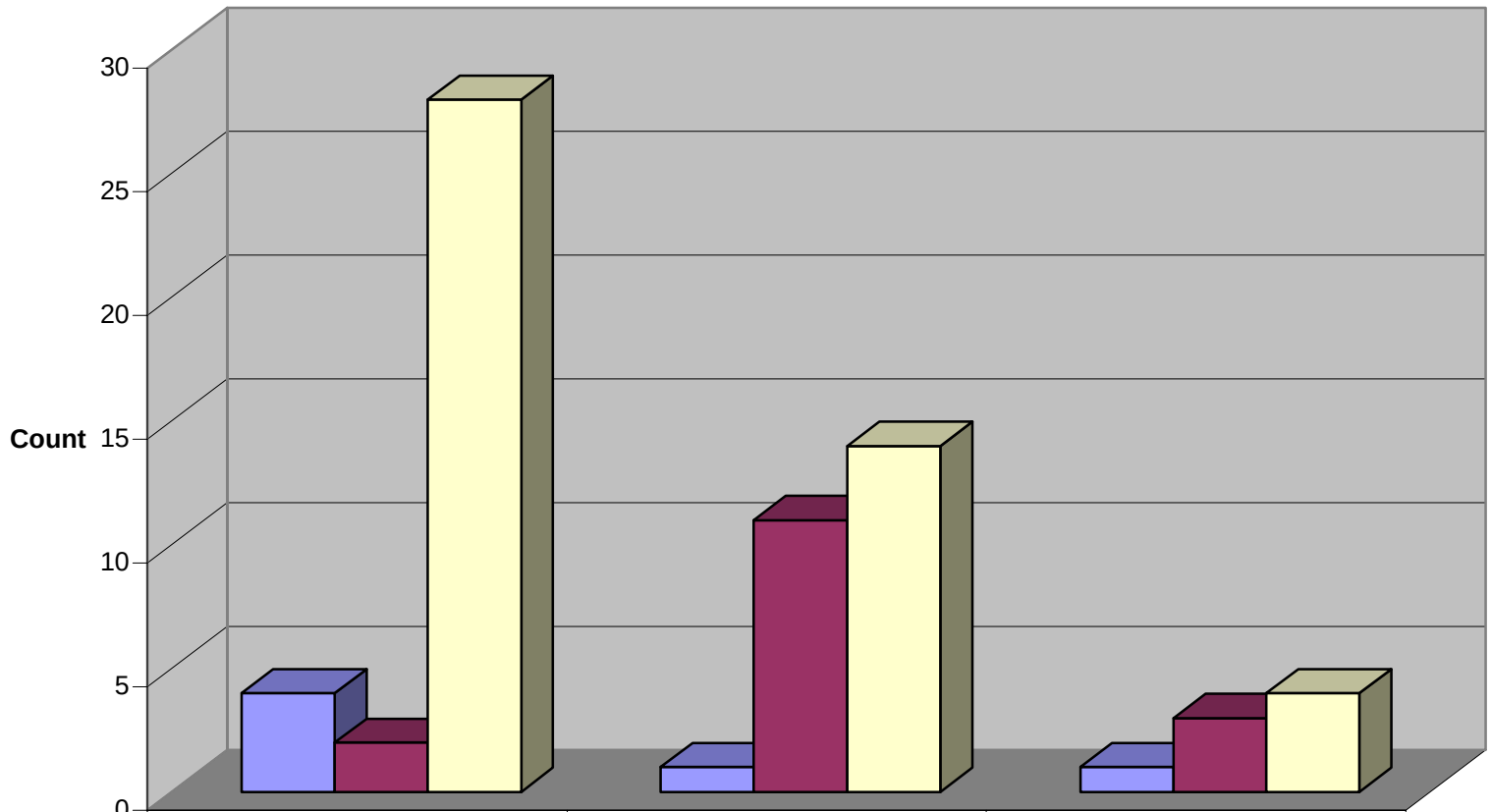
	Isolated	Small Town	Large Town
Specialty	1	2	3
Family Practice/Multi-specialties	6	7	4
Family Practice Only	26	13	8

Age of Clinic and Type of Clinic



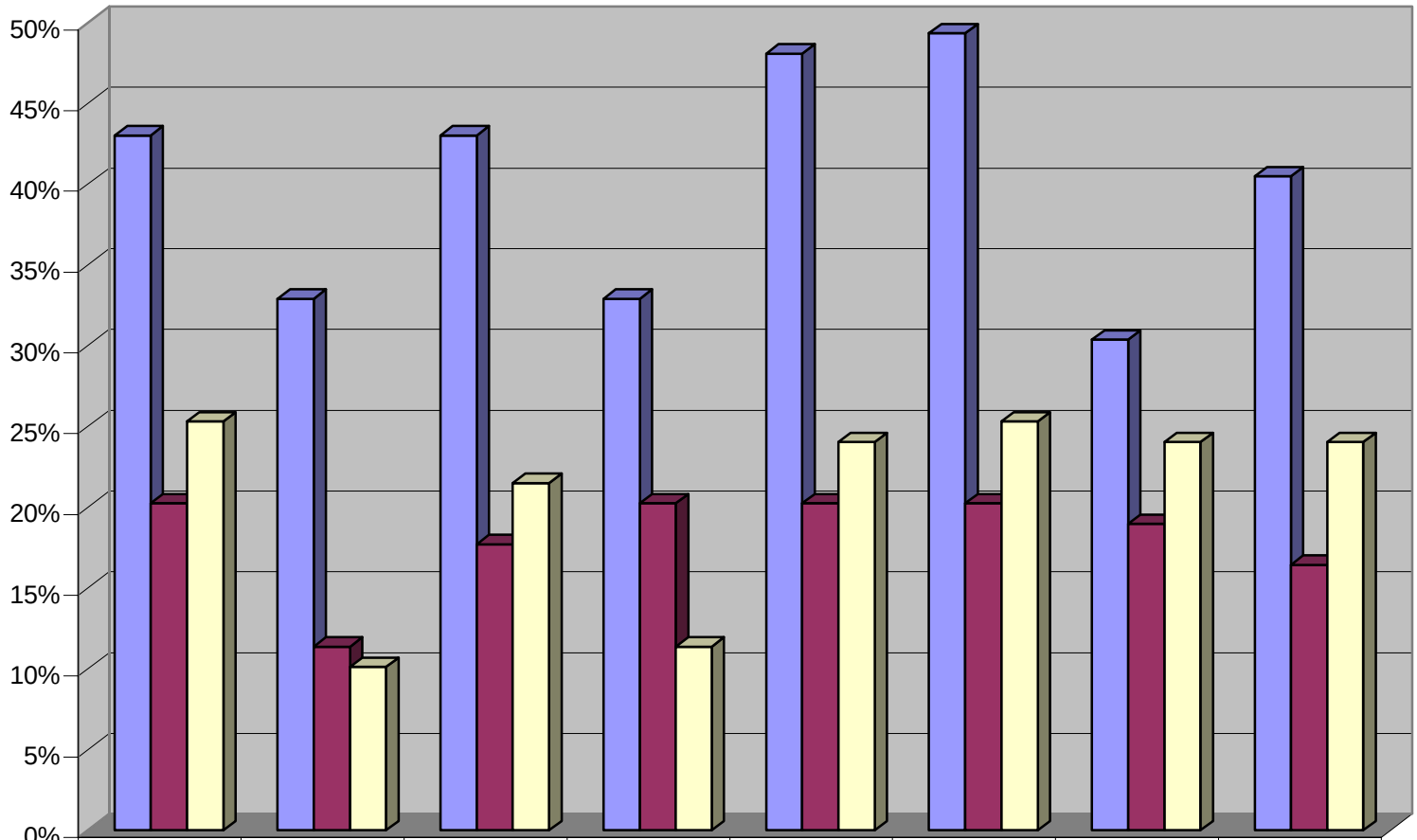
	Two Years and Less	Three Years and More
Specialty	3	3
Family Practice/Multi-specialties	7	10
Family Practice Only	6	37

Type of Clinic by Number of Physicians



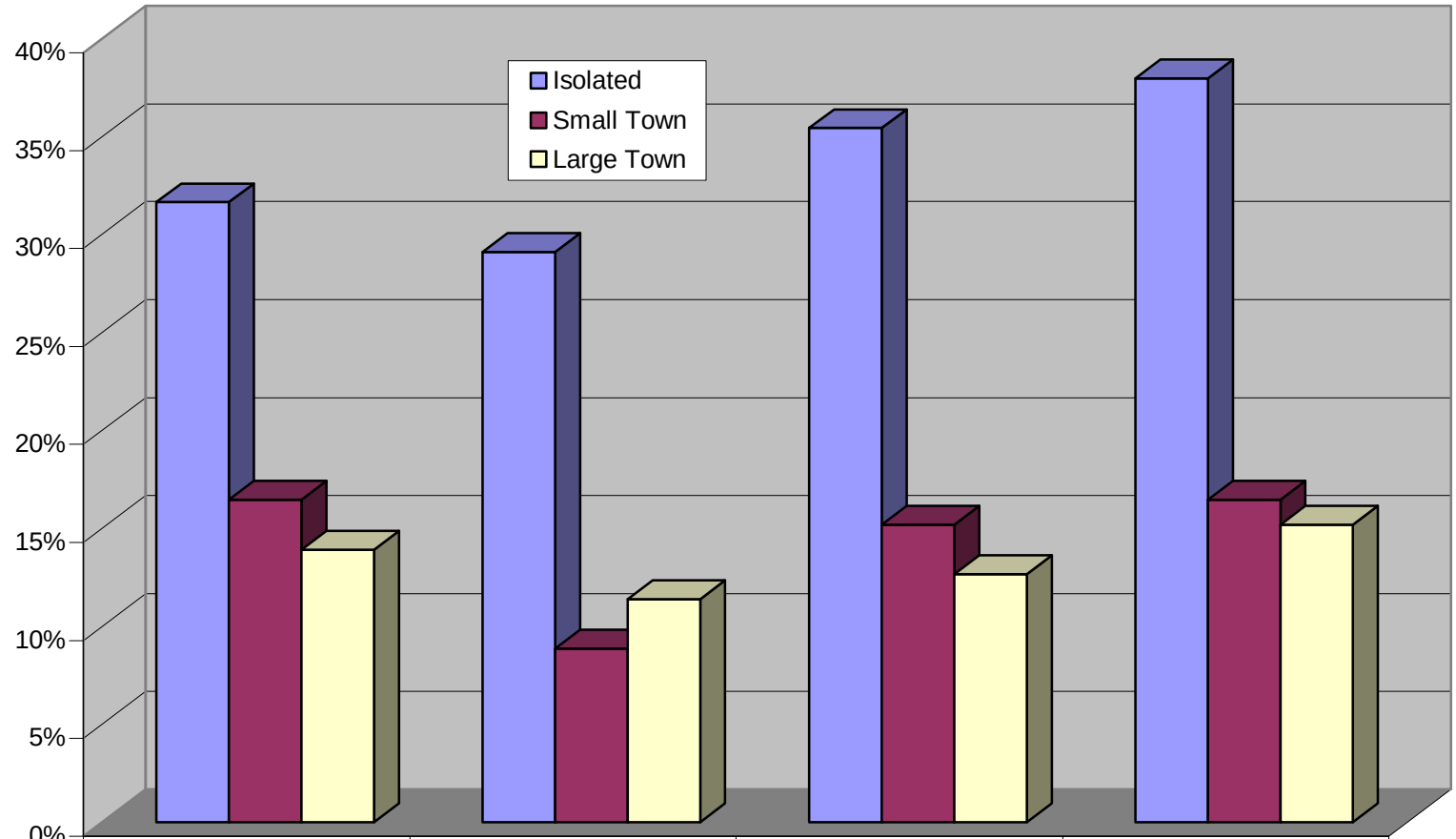
	0-2 Physicians	2-5 Physicians	More than 5 Physicians
Specialty	4	1	1
Family Practice/Multi-specialties	2	11	3
Family Practice Only	28	14	4

General Medical Services Provided by RUCA Clinic Type



	General Primary Medical Care	Emergency Medical Services	Urgent Medical Care	24 hour coverage***	Family Planning	Immunizations	Following Hospitalized Patients***	Following Long term Care Patients
Isolated	43%	33%	43%	33%	48%	49%	30%	41%
Large Town	20%	11%	18%	20%	20%	20%	19%	16%
Small Town	25%	10%	22%	11%	24%	25%	24%	24%

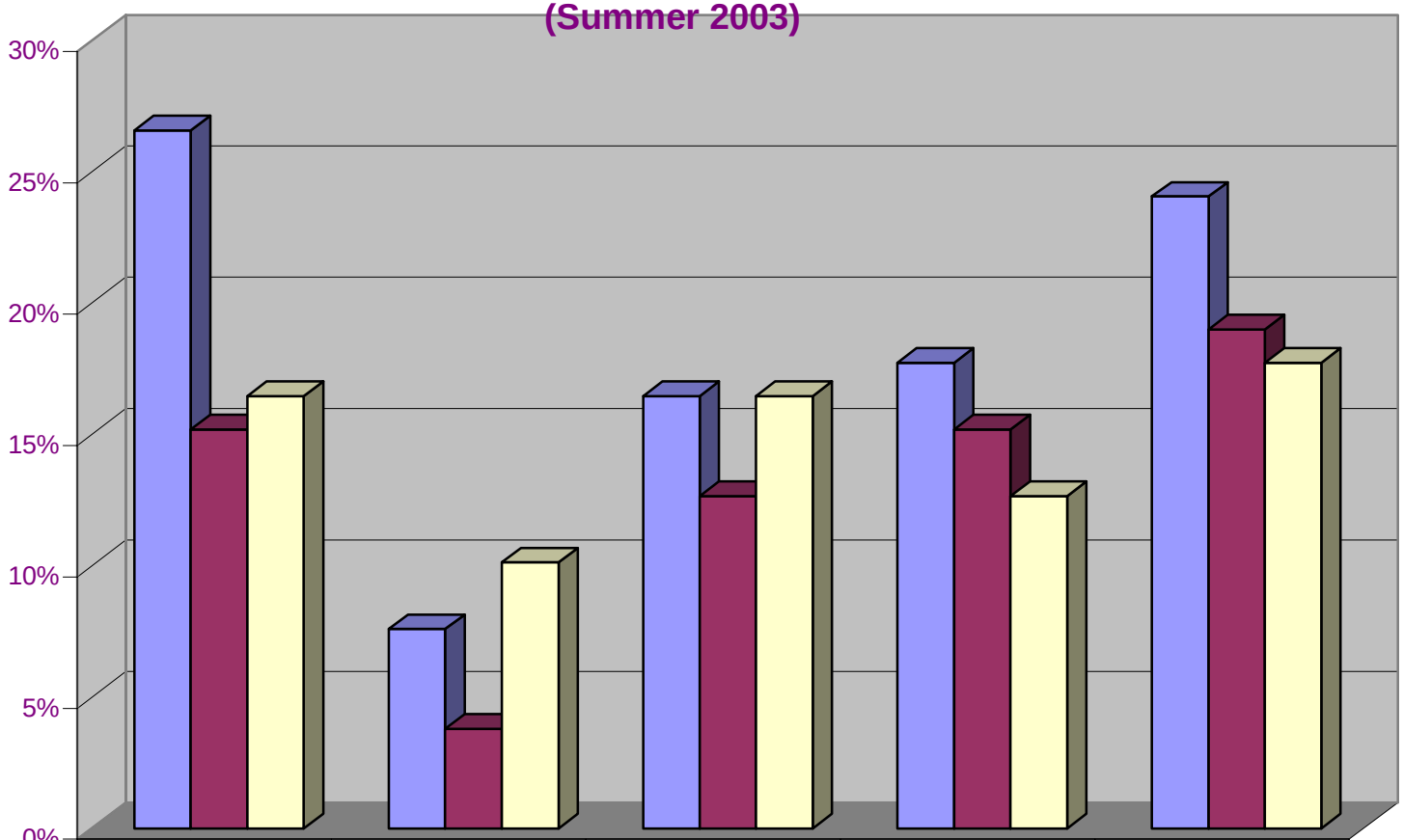
Diagnostic Services Provided by RUCA Code



	Diagnostic Laboratory	Diagnostic X-ray Procedures	Diagnostic Tests/Screenings	HIV Testing
Isolated	32%	29%	35%	38%
Small Town	16%	9%	15%	16%
Large Town	14%	11%	13%	15%

Percentage of RHC Providing Obstetrical Care

(Summer 2003)



	Prenatal care	Ultrasound	Labor and Delivery Professional care	Ante partum Fetal Assessment	Postpartum care
Isolated	27%	8%	16%	18%	24%
Small Town	15%	4%	13%	15%	19%
Large Town	16%	10%	16%	13%	18%

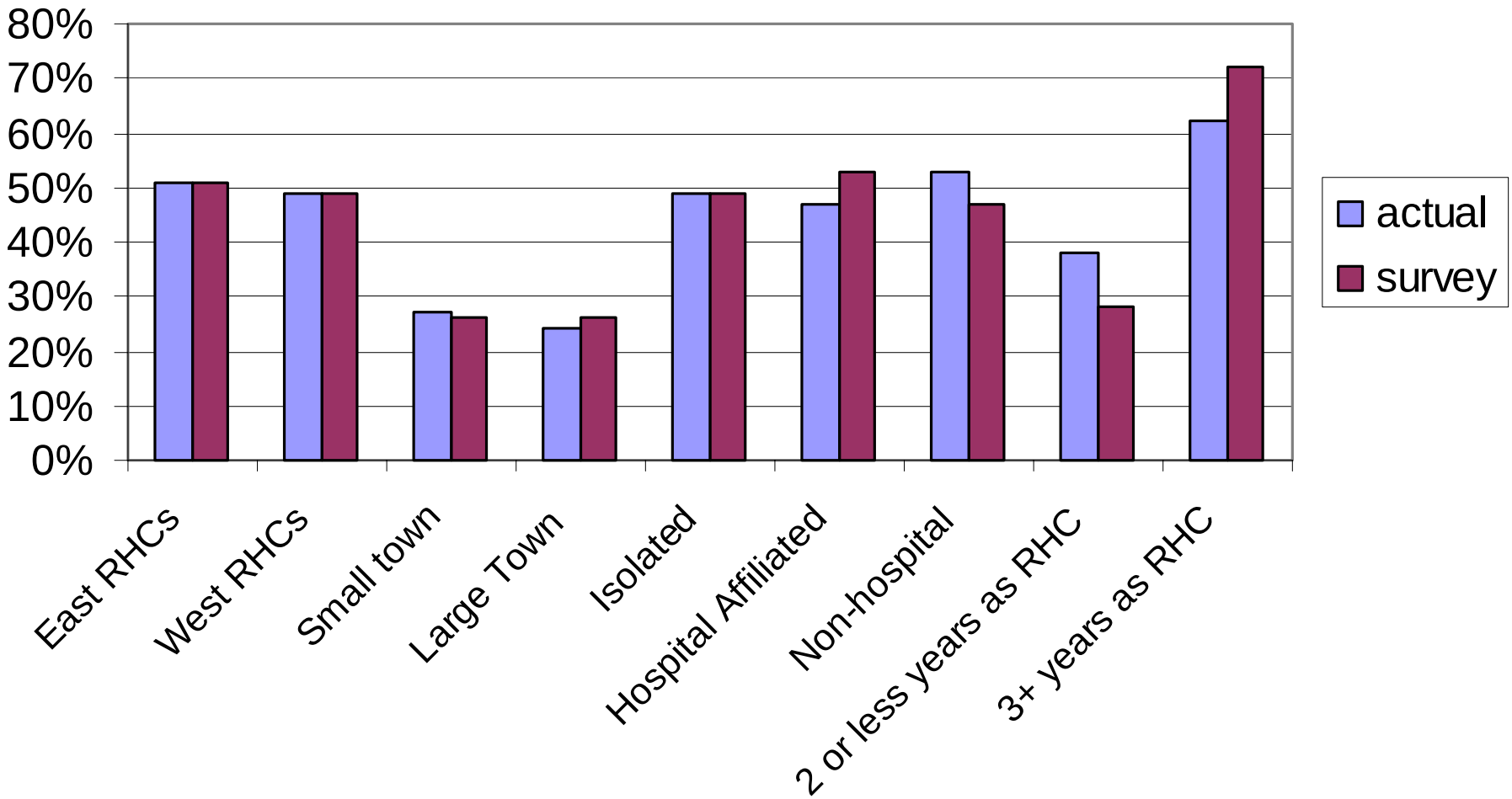
FINANCIAL AND PRODUCTIVITY RESULTS

- All certified RHC's in Washington State as of 08/03
- N=43 out of 102 possible
- Analysts: East West Consulting
  - Larry Thompson
  - Chelle Davidson
- Data compiled for CY 2002

METHODOLOGY

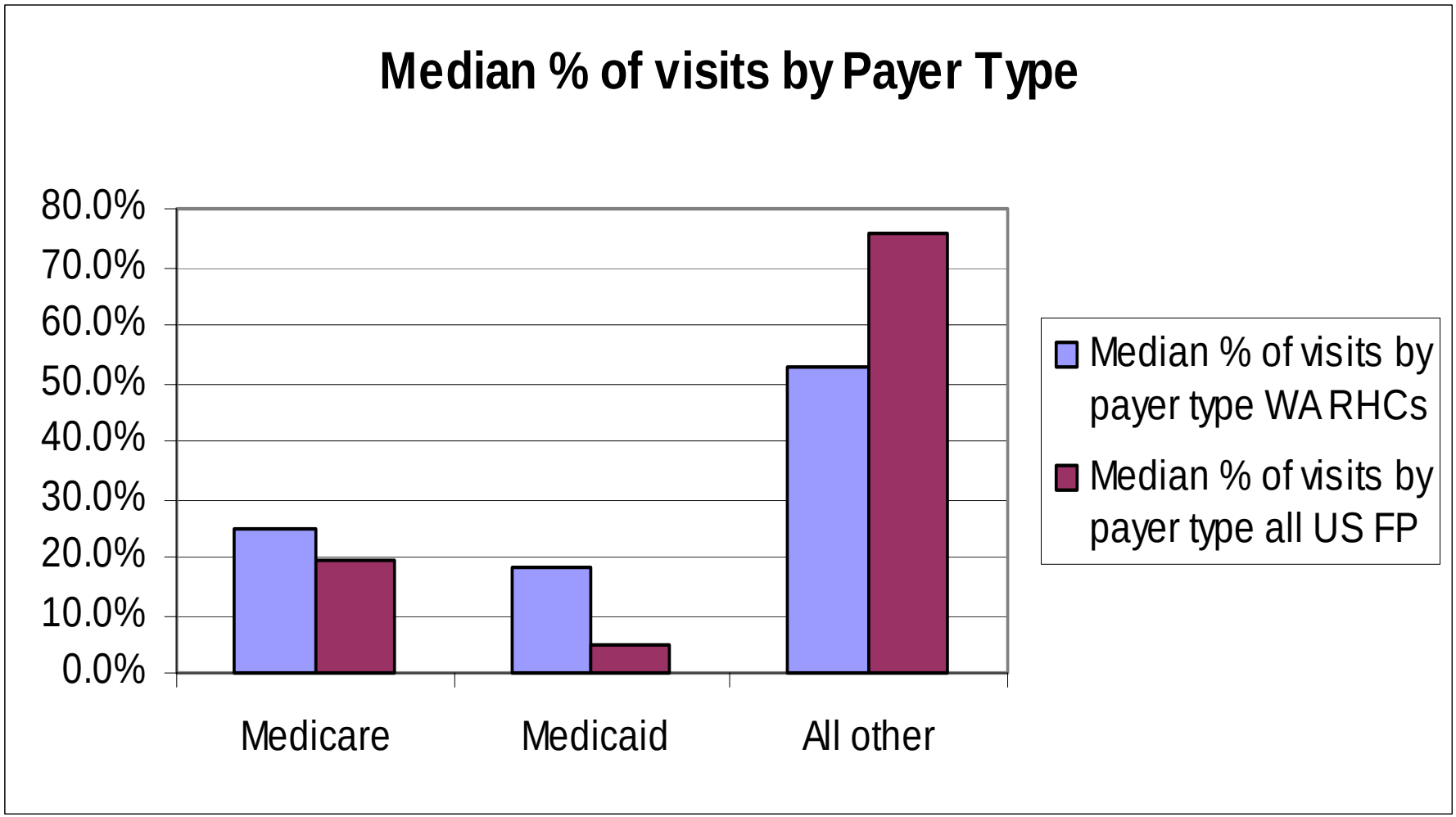
- Separate financial/productivity survey
- Modeled on clinic chart of accounts or DER
- Intent was to measure *overall* financial performance
- Intent was to facilitate benchmarking to external standards
- Survey instrument peer review
- Data follow-up and scrubbing

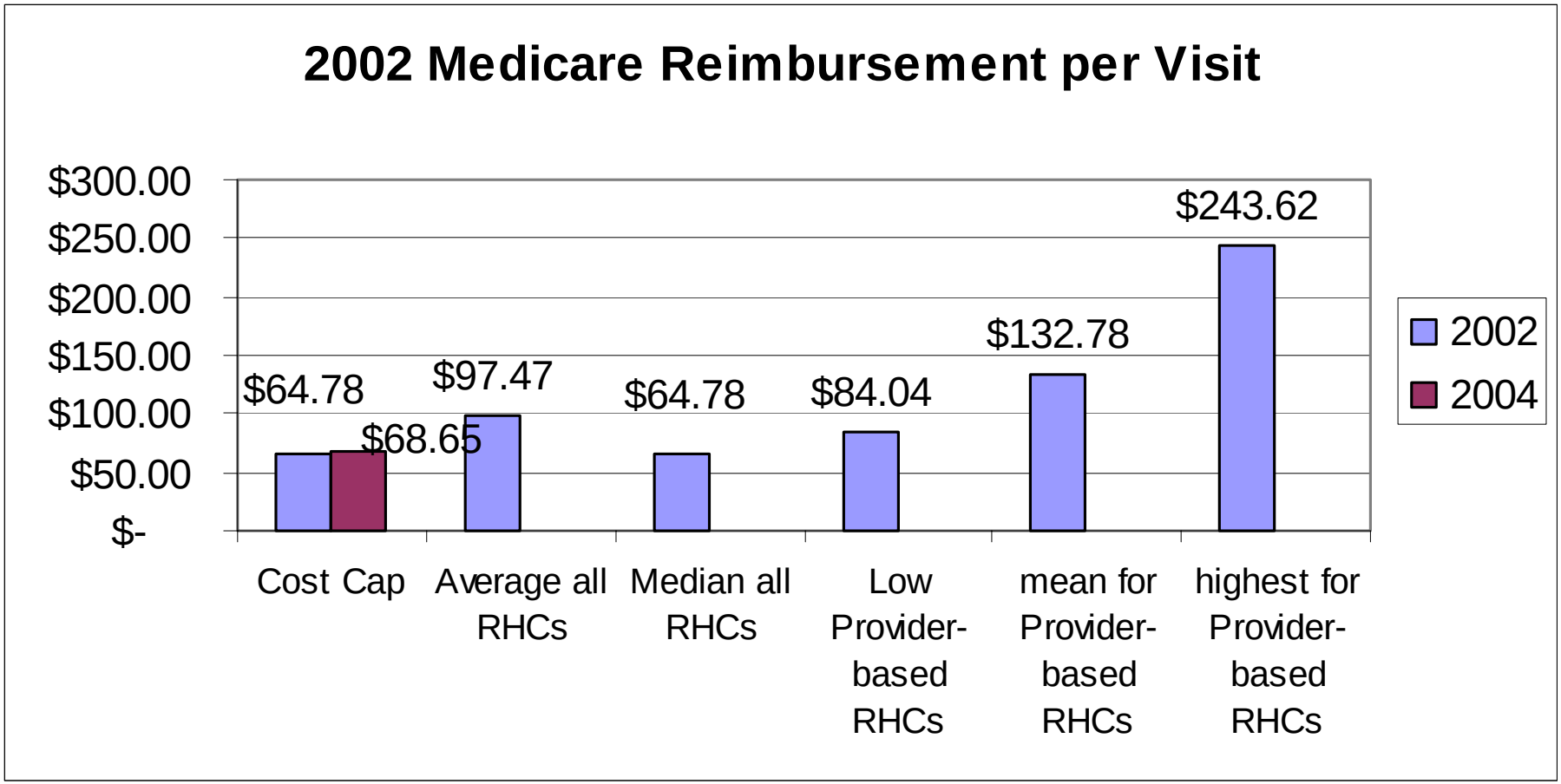
Sample in Comparison to All RHCs

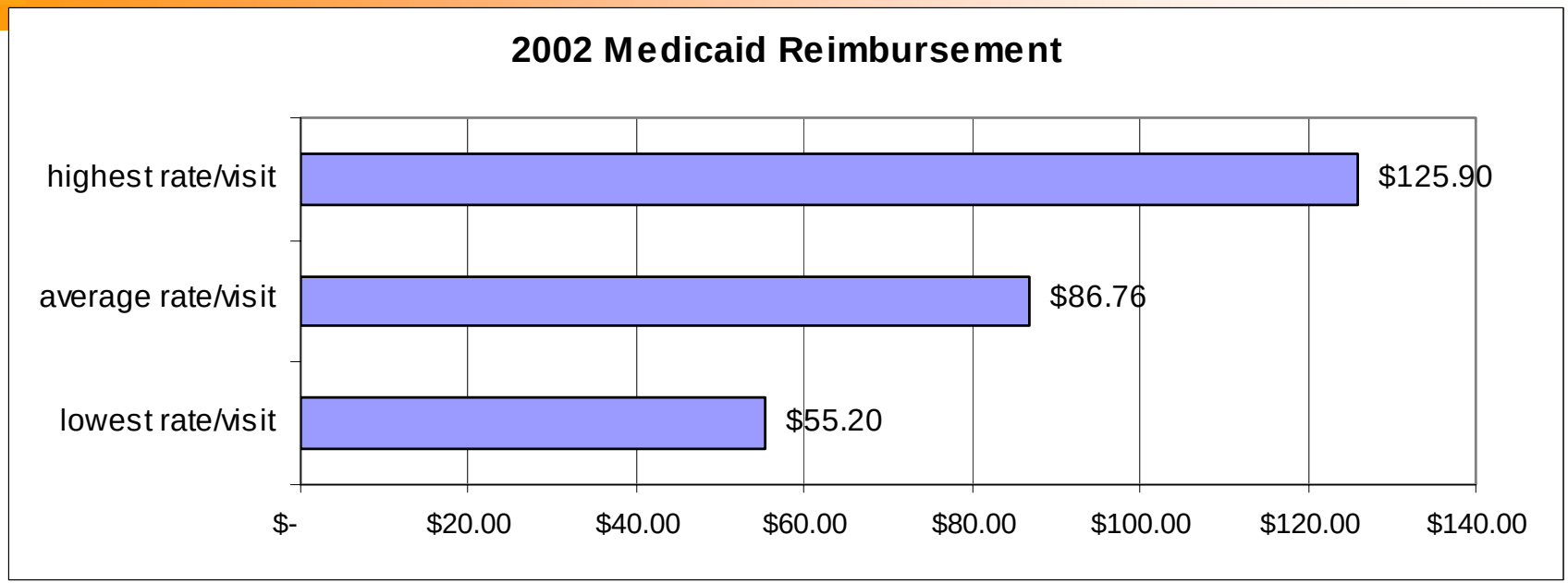


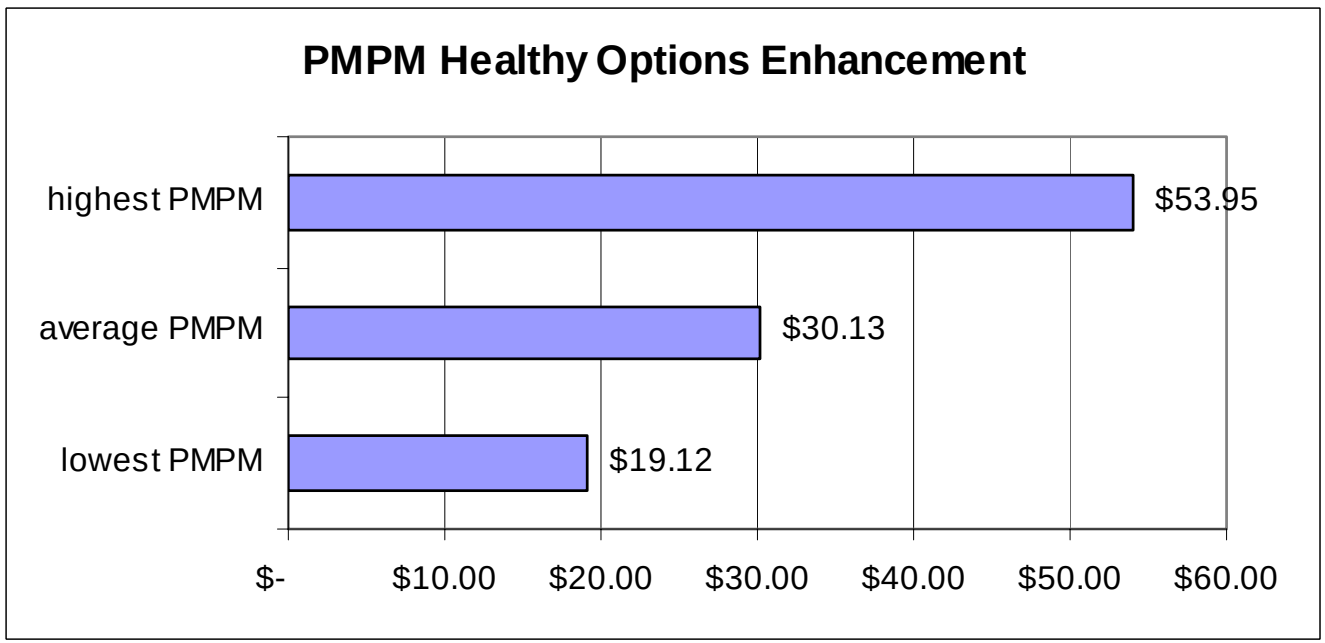
RHC REIMBURSEMENT

- Reimbursement grouped into three buckets: Medicare, Medicaid, all other
- Medicare and Medicaid are variations of cost reimbursement
- Policy intent was to reward increased share of Medicare, Medicaid, and un-sponsored patients


Median % of visits by Payer Type
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
Medicare
Medicaid
All other
Median % of visits by payer type WA RHCs
Median % of visits by payer type all US FP


2002 Medicare Reimbursement per Visit
$300.00
$250.00
$200.00
$150.00
$100.00
$50.00
$-
$64.78
$68.65
$97.47
$64.78
$84.04
$132.78
$243.62
2002
2004
Cost Cap
Average all RHCs
Median all RHCs
Low Provider-based RHCs
mean for Provider-based RHCs
highest for Provider-based RHCs


2002 Medicaid Reimbursement
highest rate/visit
average rate/visit
lowest rate/visit
$125.90
$86.76
$55.20
$-
$20.00
$40.00
$60.00
$80.00
$100.00
$120.00
$140.00


PMPM Healthy Options Enhancement
highest PMPM
average PMPM
lowest PMPM
$53.95
$30.13
$19.12
$-
$10.00
$20.00
$30.00
$40.00
$50.00
$60.00

KEYS TO SUCCESS: DEFINING FINANCIAL BEST PRACTICES

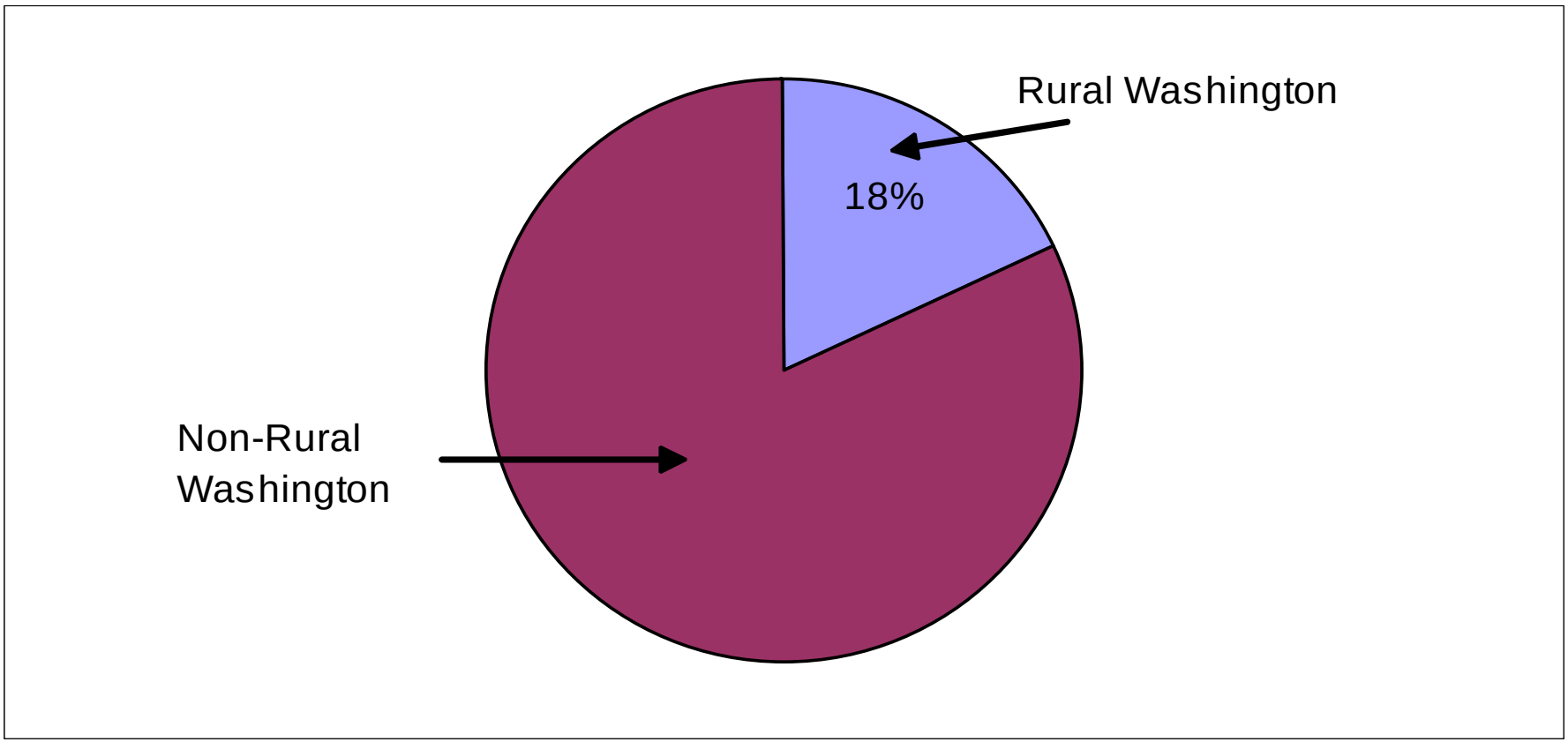
- Providers are Productive
- Clinic receives sufficient revenue per visit
- Clinic is able to pay competitive provider salaries
- Clinic reasonably controls its expenses

BEST PRACTICES CHARACTERISTICS

- Higher than average revenue/visit
- Below average overhead rates
- Superior AR performance
- Had at least 2 MDs
- Average use of mid-levels
- Higher ratio of support to physician
- Most were multi-specialty
- Below average Medicare and Medicaid encounter rate

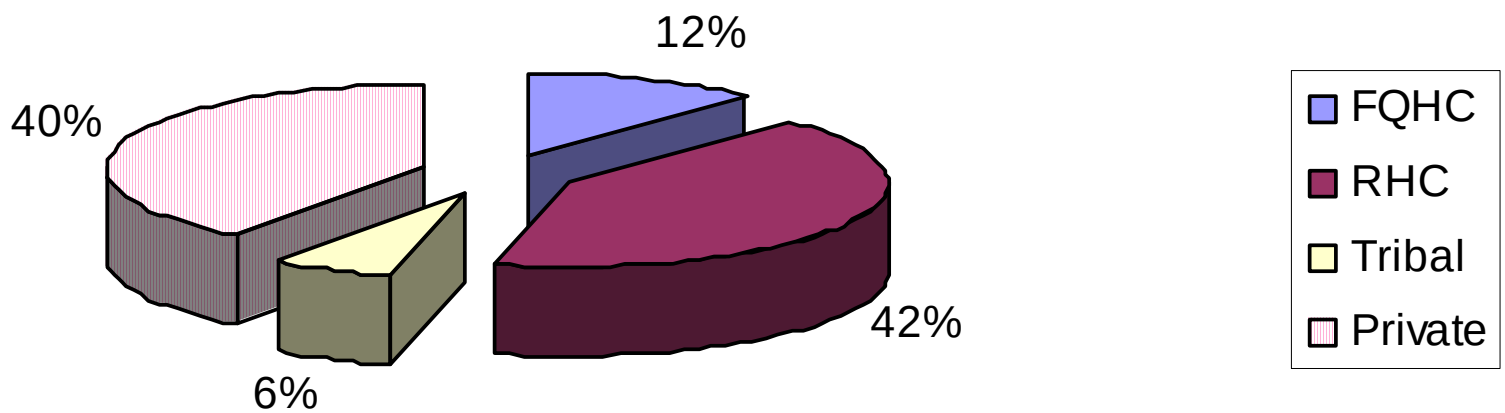
WHAT IS THE ROLE OF THESE RHCs IN THE WASHINGTON HEALTH SYSTEM?

HOW MUCH OF THE STATE IS RURAL?



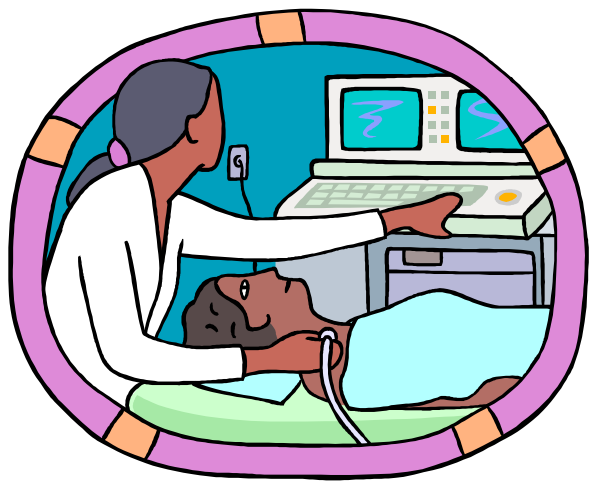
1,048,893 rural residents in 2000

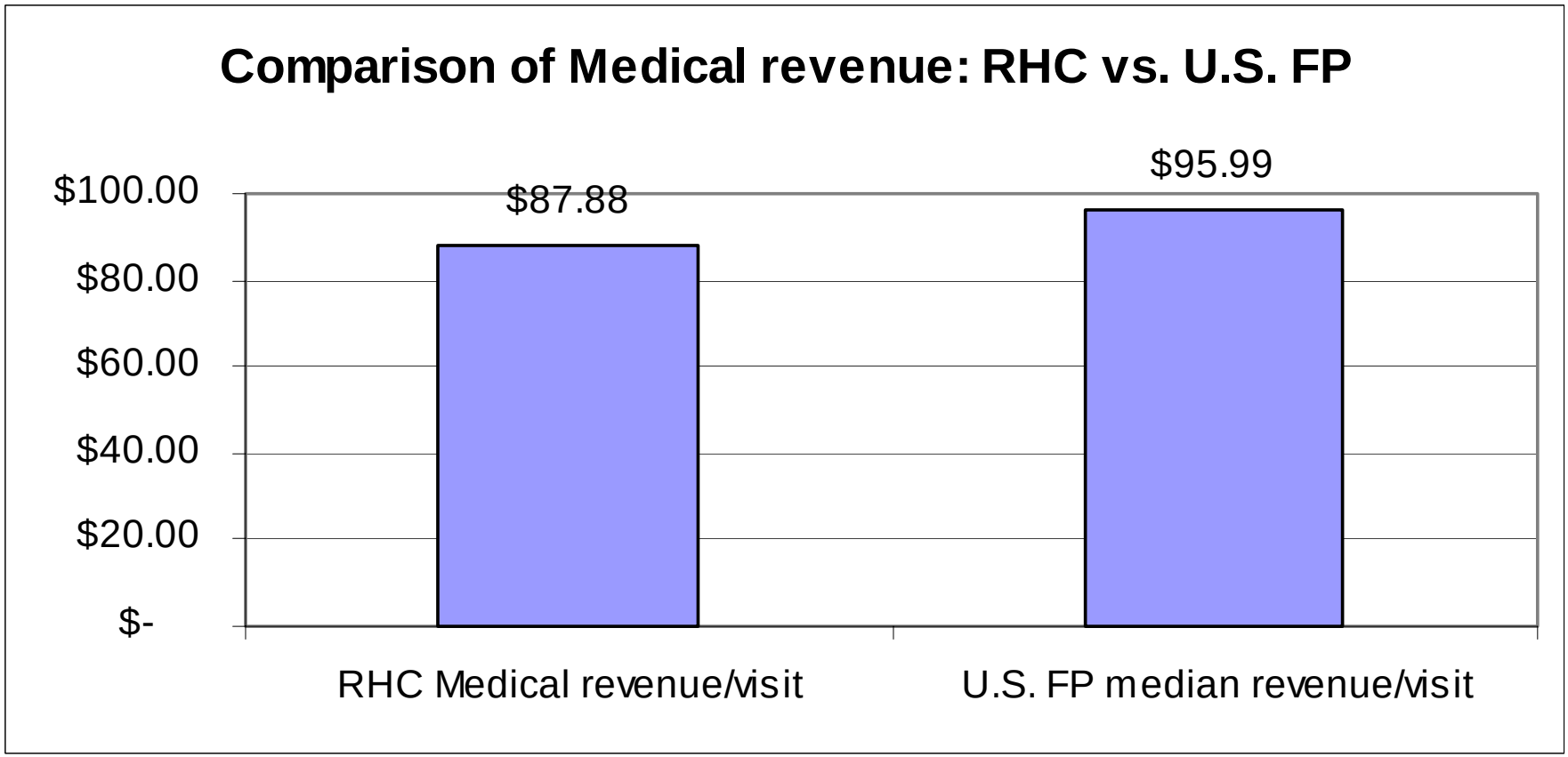
Distribution of Rural Washington Primary Care Physician by Type of Clinic



- Private care diminishing rapidly
- 102 RHCs had $216,590,000 in net medical revenue
- 1.1% of total Washington personal health spending
- 3.7% of State spending for physician services
- RHCs are 9.4% of total per capita rural health spending
- RHCs are 29% of rural spending for physician services
- Small amounts of spending (targeted subsidy) generate a large impact in rural Washington.

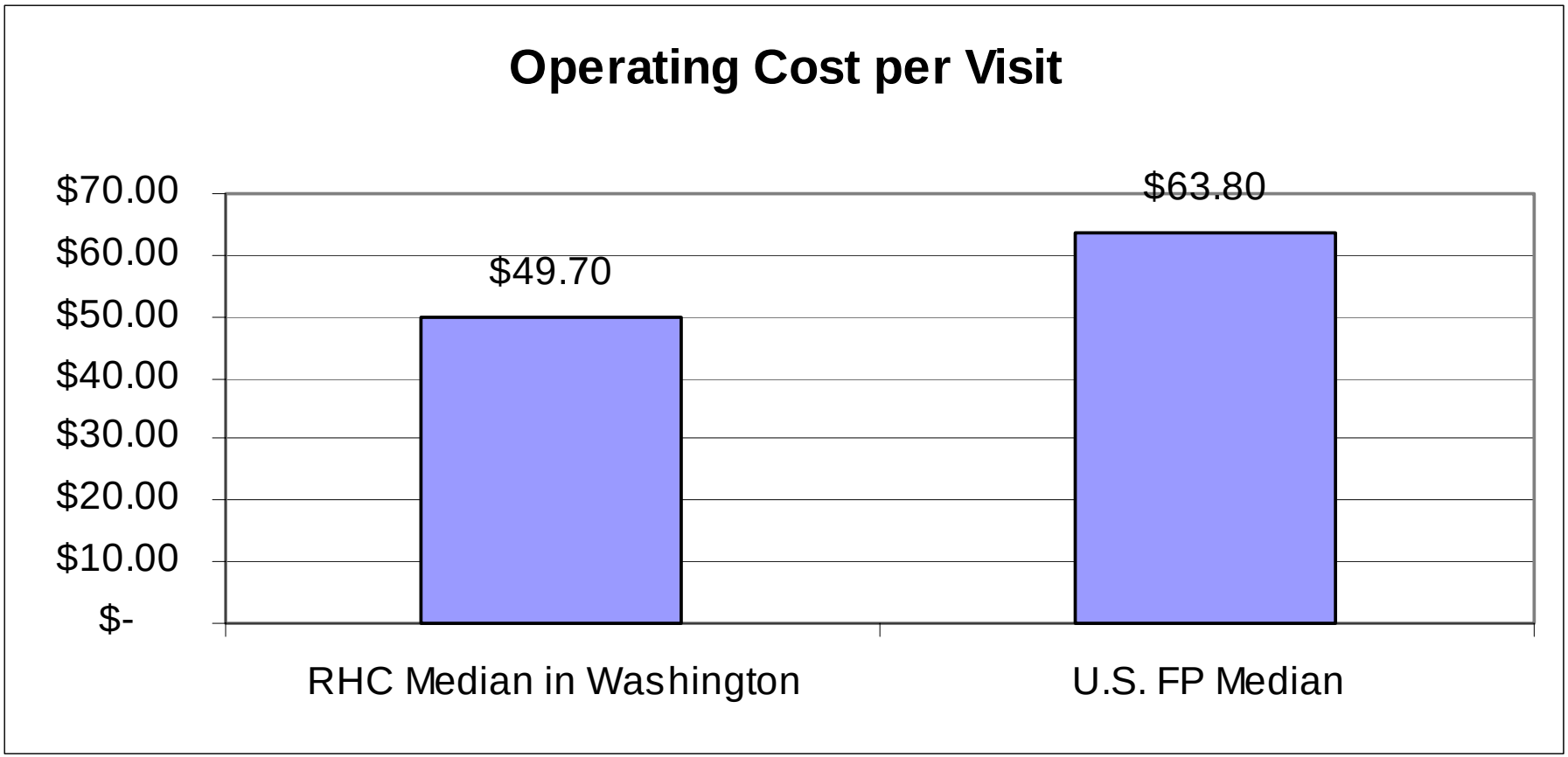
OVERVIEW OF RHC OPERATING CHARACTERISTICS

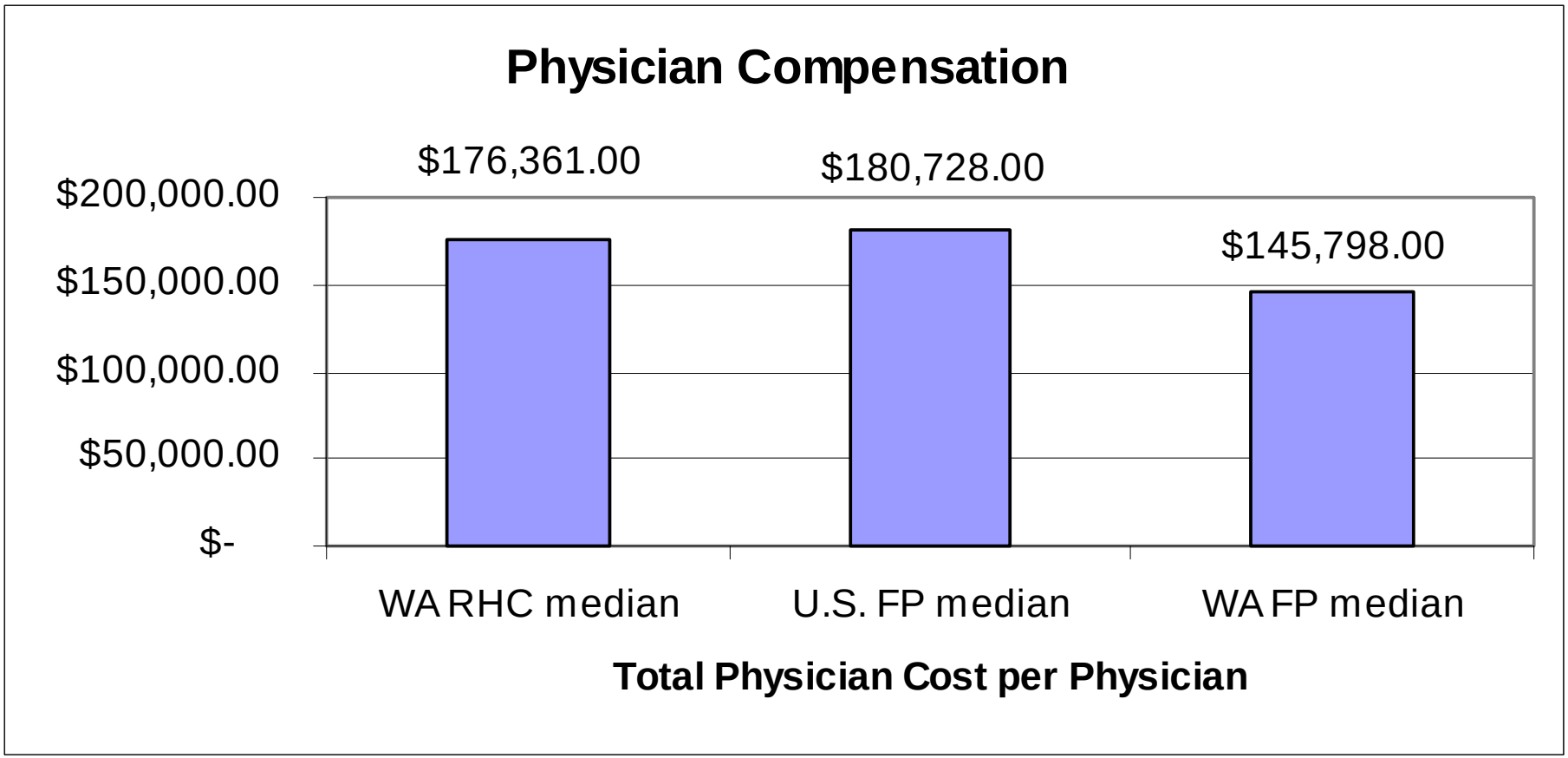



Comparison of Medical revenue: RHC vs. U.S. FP
$100.00
$80.00
$60.00
$40.00
$20.00
$-
$87.88
$95.99
RHC Medical revenue/visit
U.S. FP median revenue/visit

REVENUE

- Median medical revenue per RHC physician: $471,499
- U.S. FP median medical revenue/physician: $470,775
- Extensive use of mid-levels drives the difference


Operating Cost per Visit
$70.00
$60.00
$50.00
$40.00
$30.00
$20.00
$10.00
$-
$49.70
$63.80
RHC Median in Washington
U.S. FP Median

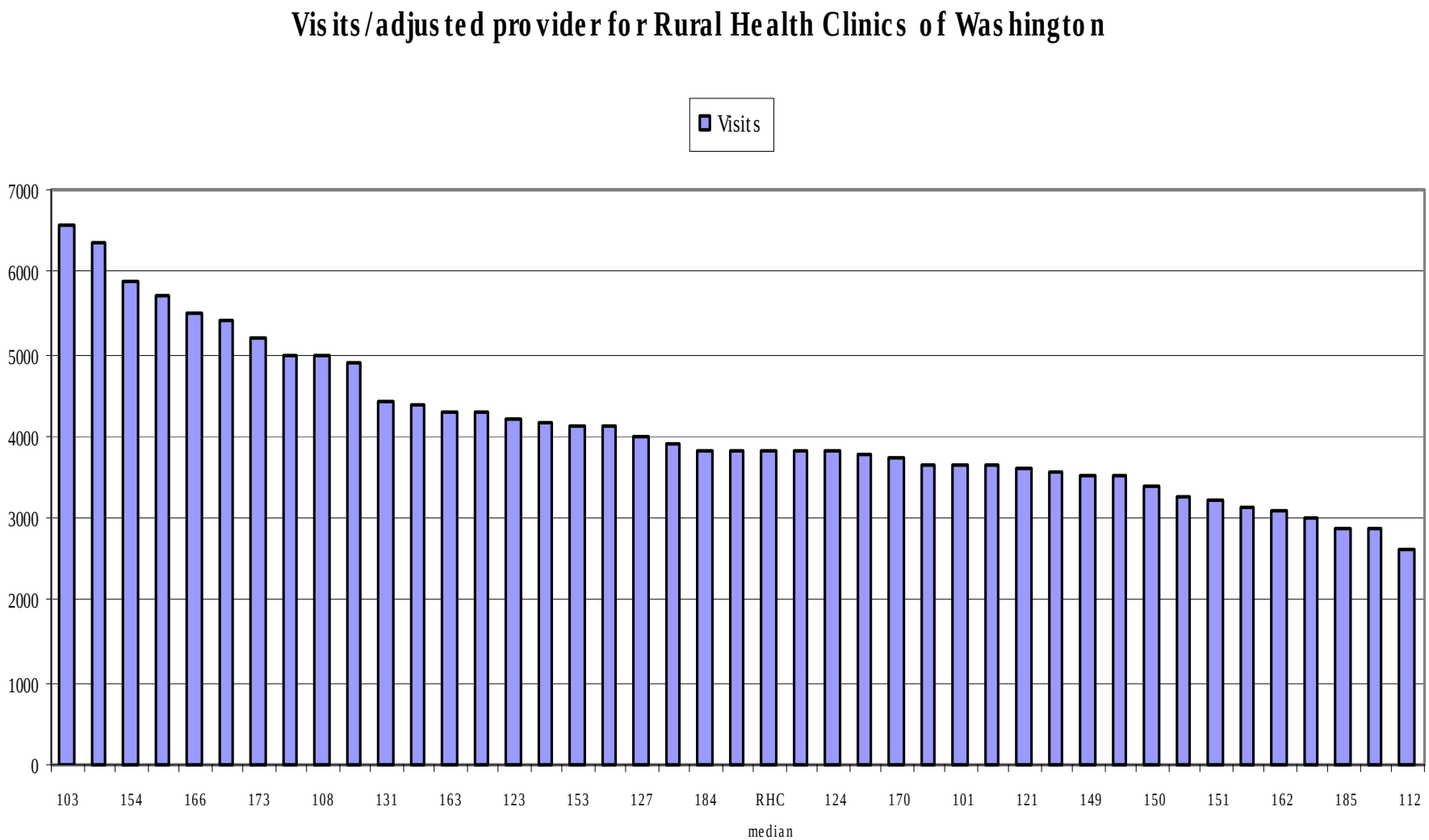

Physician Compensation
$176,361.00
$180,728.00
$145,798.00
$200,000.00
$150,000.00
$100,000.00
$50,000.00
$-
WA RHC median
U.S. FP median
WA FP median
Total Physician Cost per Physician

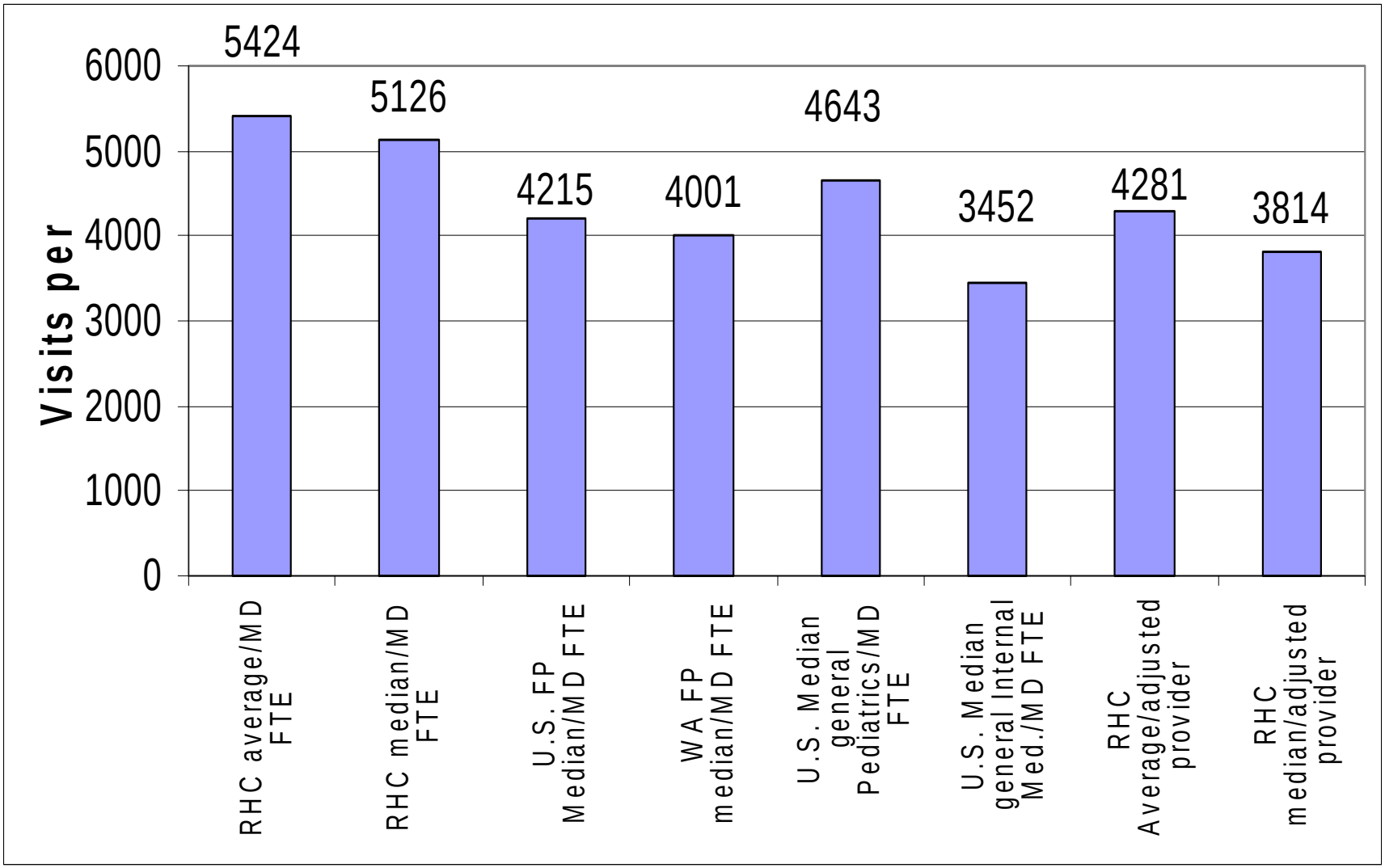
WASHINGTON RHC OVERVIEW

- Large variation in operating margin
- 42% had an operating loss in 2002
- Overhead rate (60%) very close to State and U.S. averages

PRODUCTIVITY OVERVIEW

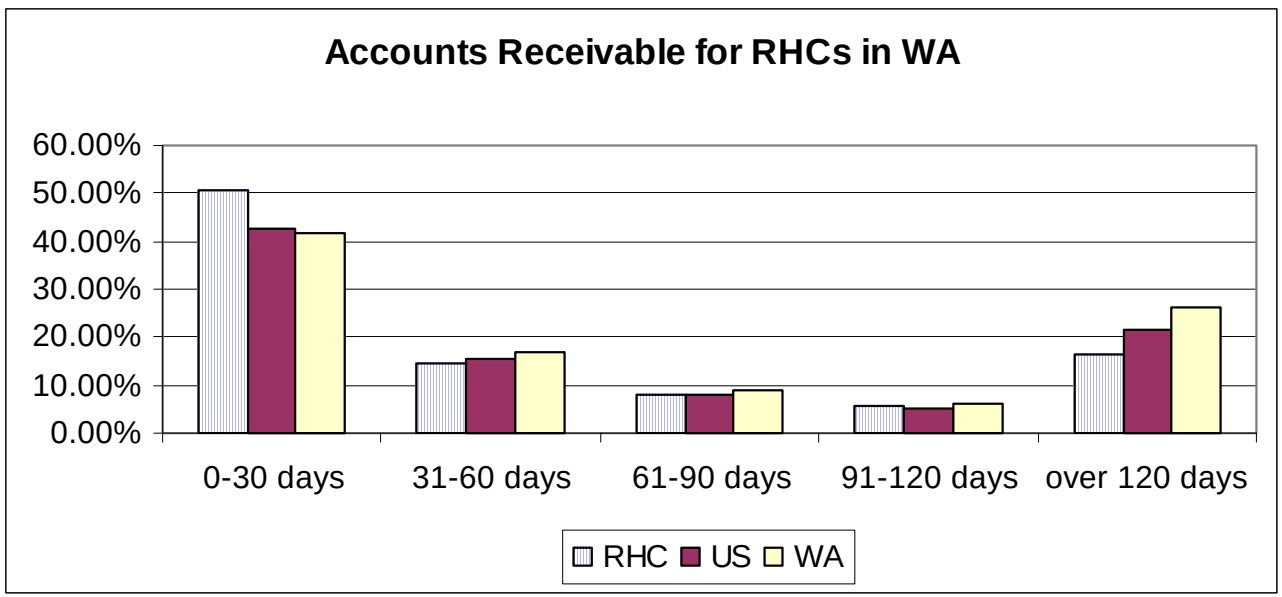
- Range of visits was 1,438 to 129,689
- Median # of visits was 9,810 vs. 24,572 U.S. average for primary care clinics
- All together, the 102 RHCs did about 1.62 million visits
- In WA RHCs there were .74 mid-levels per physician
- In U.S. primary care practices, there are .45 mid-levels per physician
- Highly productive, due to use of mid-levels
- When adjusting for mid-levels, productivity was less impressive

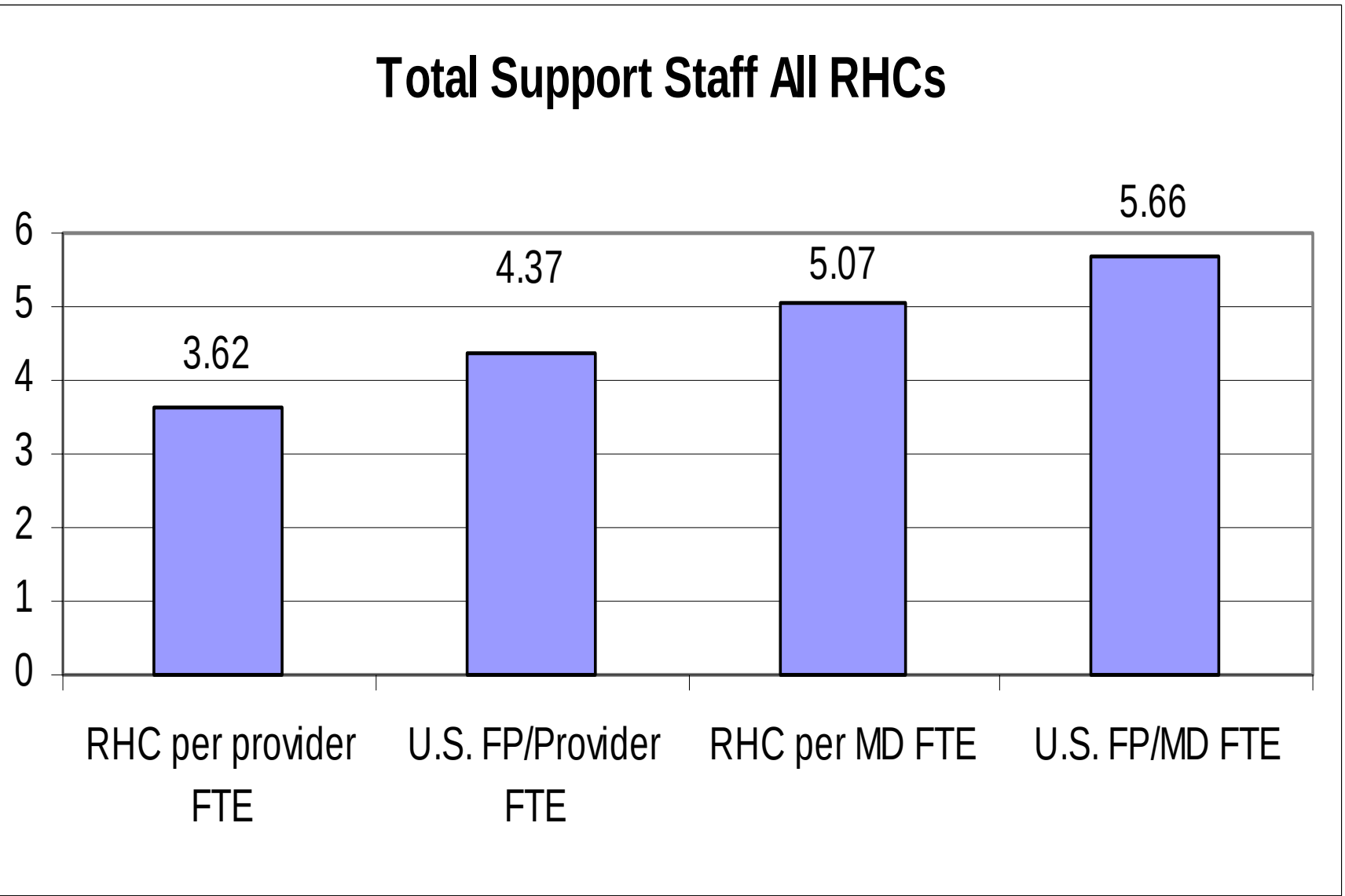

Visits/adjusted provider for Rural Health Clinics of Washington
Visits
7000
6000
5000
4000
3000
2000
1000
0
103
154
166
173
108
131
163
123
153
127
184
RHC
124
170
101
121
149
150
151
162
185
112
median

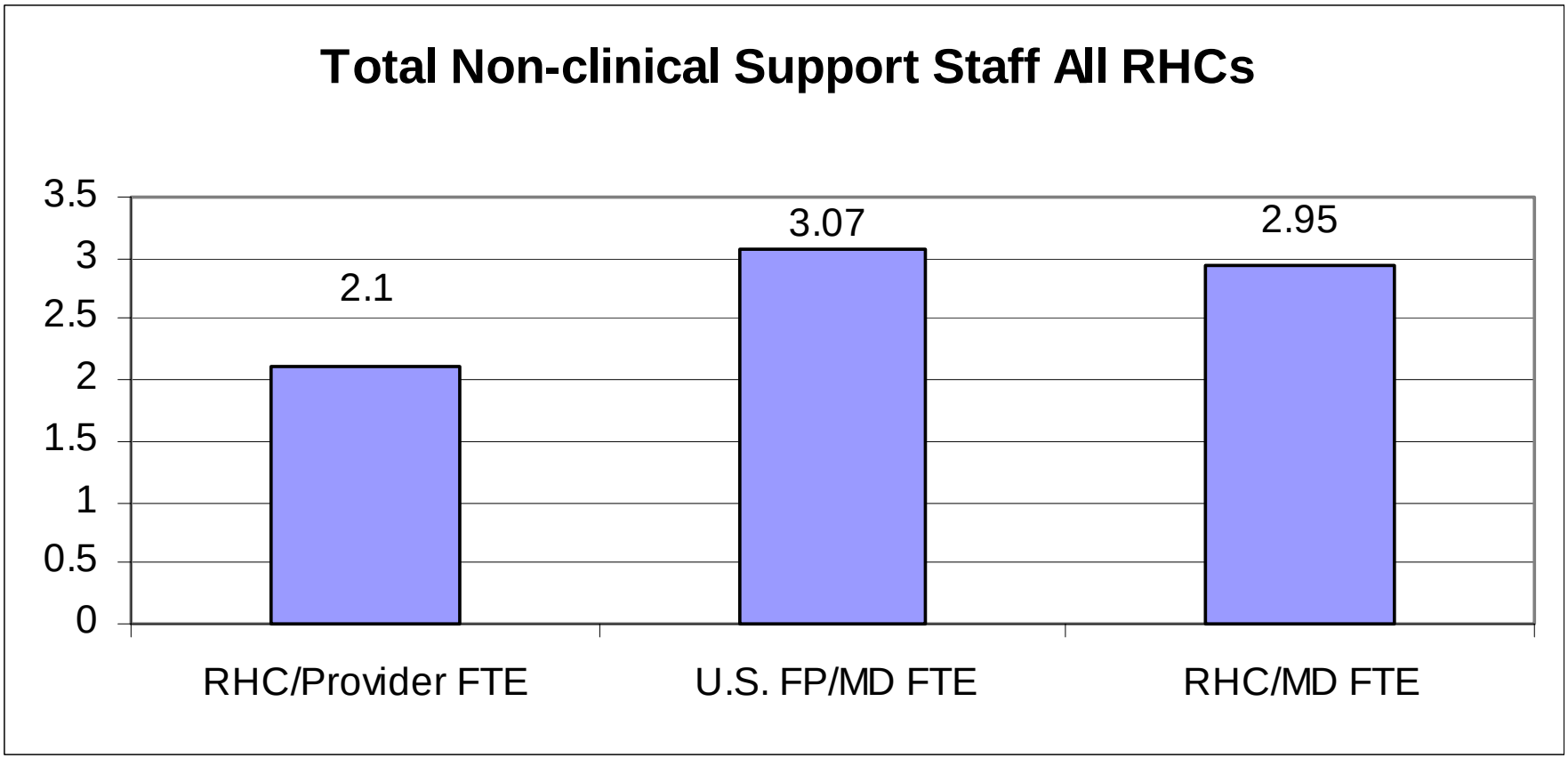

Visits per
6000
5000
4000
3000
2000
1000
0
5424
5126
4215
4001
4643
3452
4281
3814
RHC average/MD FTE
RHC median/MD FTE
U.S. FP Median/MD FTE
WA FP median/MD FTE
U.S. Median general Pediatrics/MD FTE
U.S. Median general Internal Med./MD FTE
RHC Average/adjusted provider
RHC median/adjusted provider

ACCOUNTS RECEIVABLE OVERVIEW

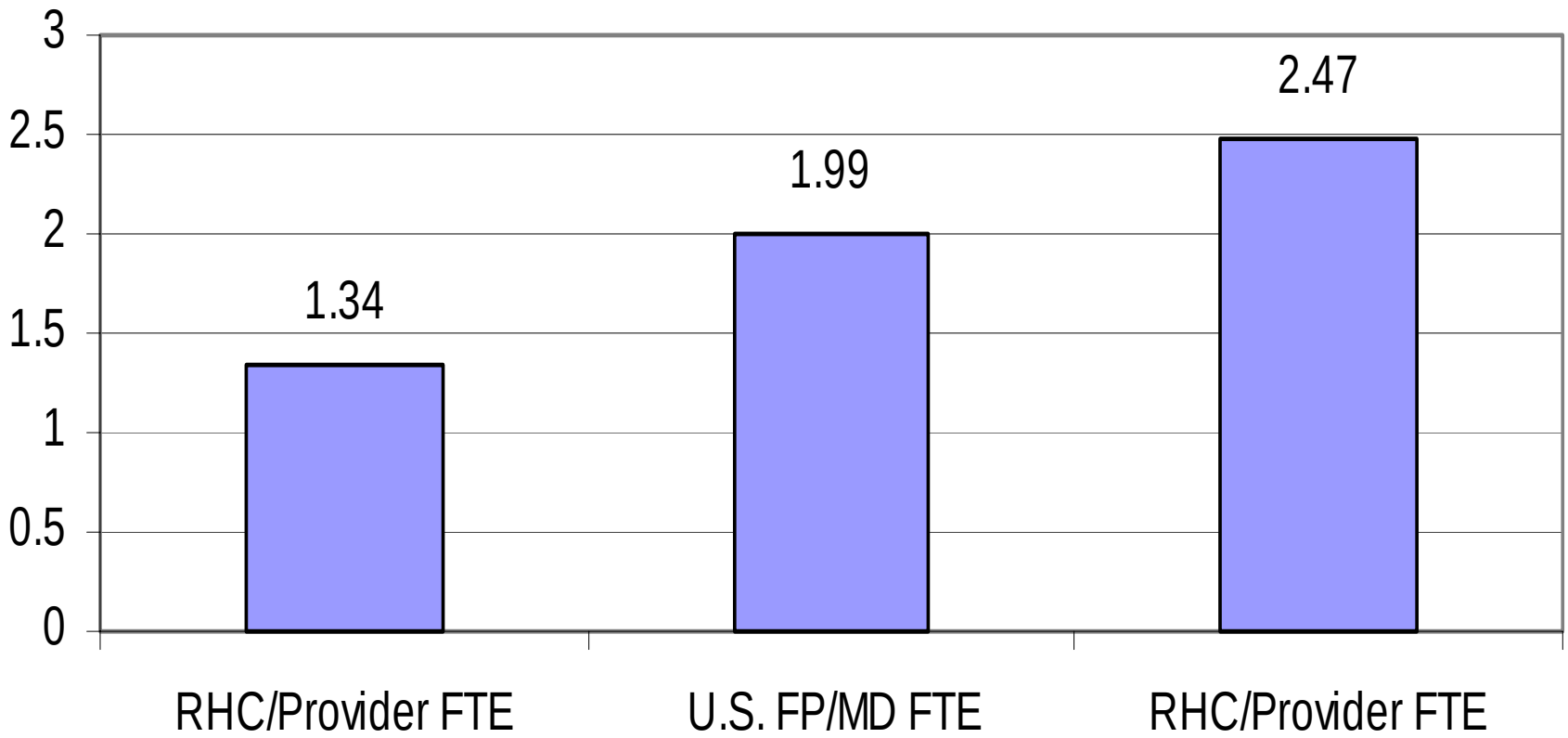
- As a group, WA RHCs perform well in managing AR
- Likely due to Medicare and Medicaid electronic billing



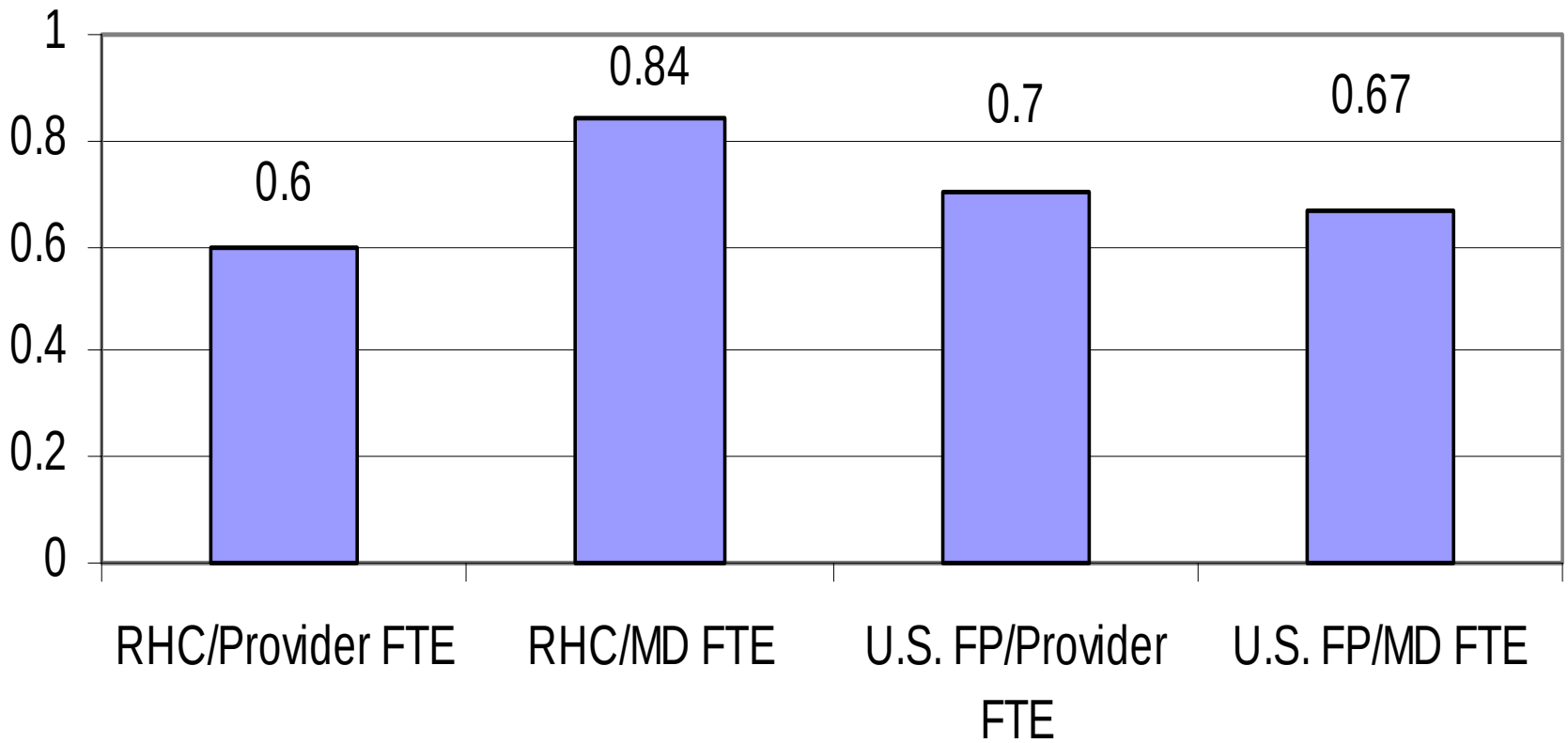

Total Support Staff All RHCs
6
5
4
3
2
1
0
3.62
4.37
5.07
5.66
RHC per provider FTE
U.S. FP/Provider FTE
RHC per MD FTE
U.S. FP/MD FTE


Total Non-clinical Support Staff All RHCs
3.5
3
2.5
2
1.5
1
0.5
0
2.1
3.07
2.95
RHC/Provider FTE
U.S. FP/MD FTE
RHC/MD FTE

Total Clinical Support Staff: All RHCs



Total Business Office Staff: All RHcs



RHCs Totals for 43 Clinics: 4/22/04

CLINIC ID	average	Median	MGMA U.S. FP Median	MGMA WA FP Median
Utilization Statistics				
total visits	**18,882**	**9,810**		
total visits/MD FTE	**5,424**	**5,126**	4,215.00	4,001.00
Total visits/adjusted Provider	**4,281**	**3,814**	5,877.00	5,290.00
Medicare visits	**4,252**	**1,984**		
% Medicare visits	**25%**	**25%**	19.48%	
Medicaid visits	**2,960**	**1,678**		
% Medicaid visits	**22%**	**20%**	5.00%	
Total other visits	**9,744**	**5,248**		
% other visits	**56%**	**53%**	76.00%	
2000 population in defined service area				
Market share in area by payor type				
Financial Statistics				
Total medical revenue	**$ 2,227,015.84**	**$ 855,786.00**		
total medical revenue/visit	**$ 86.75**	**$ 87.88**	$ 95.99	
total medical revenue/MD FTE	**$ 484,527.83**	**$ 471,499.44**	$ 470,775.00	$ 460,913.00
Total support staff FTE cost	**$ 698,220.34**	**$ 280,256.00**		
total support staff/MD FTE	**$ 165,385.60**	**$ 150,841.08**		
Other operating costs	**$ 552,040.81**	**$ 229,469.59**		
Other operating costs/MD FTE	**$ 118,364.72**	**$ 110,465.56**		
Total operating cost	**$ 1,279,336.99**	**$ 552,984.00**		
Total operating cost/visit	**$ 54.01**	**$ 49.70**	$ 63.80	
total operating cost/MD FTE	**$ 291,632.27**	**$ 266,462.59**	$ 273,724.00	$ 245,661.00
Total medical revenue after operating cost	**$ 887,388.33**	**$ 295,334.00**		
Ttl med. Rev after operating cost/MD FTE	**$ 175,555.82**	**$ 166,789.50**	$ 192,773.00	$ 190,219.00
Total midlevel cost	**$ 125,384.10**	**$ 81,727.00**		
total midlevel cost/MD FTE	**$ 50,292.64**	**$ 41,639.77**		
Total physician cost	**$ 808,481.87**	**$ 415,405.50**		
total physician cost/MD FTE	**$ 170,411.15**	**$ 176,361.00**	$ 180,728.00	$ 145,798.00
other revenue	**$ 19,540.47**			
other revenue/MD FTE	**$ 10,969.45**			
Net Practice Income or loss	**$ 49,129.78**	***$ -***		
net Practice Income or loss/MD FTE	**$ (13,887.25)**	***$ -***		
Overhead Rate	**65%**	***62%***		
Accounts Receivable				
% of total AR 0 to 30 days	**46.37%**	***48.29%***	42.61%	41.52%
% of total AR 31 to 60 days	**15.82%**	***14.47%***	15.28%	16.89%
% of total AR 61 to 90 days	**8.81%**	***8.48%***	7.90%	9.11%
% of total AR 91 to 120 days	**9.34%**	***6.11%***	5.35%	6.29%
% of total AR over 120 days	**19.77%**	***16.54%***	21.69%	26.20%
Total % AR		***100.00%***	92.83%	100.01%
B&O as % of total cost	**14.50%**	***10.53%***	9.09%	
Descriptive Variables				
# of MD FTE	**3.87**	***2.00***	5.2	5
# of Provider FTE	**5.44**	***3.48***	8	7.25
# of support FTE	**20.41**	***9.00***	26.6	26.3
Total support FTE/provider FTE	**3.08**	***2.81***	3.33	
Total support FTE/MD FTE	**3.84**	***3.57***	5.12	4.67
support personnel exp. as % of ttl med.rev.	**33.59%**	***33.24%***	32.24	25.84%
Medicare Encounter Rate	**$ 97.47**	***$ 64.78***		
Medicaid Encounter Rate	**$ 88.68**	***$ 90.71***		
# of years as RHC	**6**	***6.00***		
Hospital or Hospital district				
Location Type				
Practice Type				
State Location				
Hospital in Community				

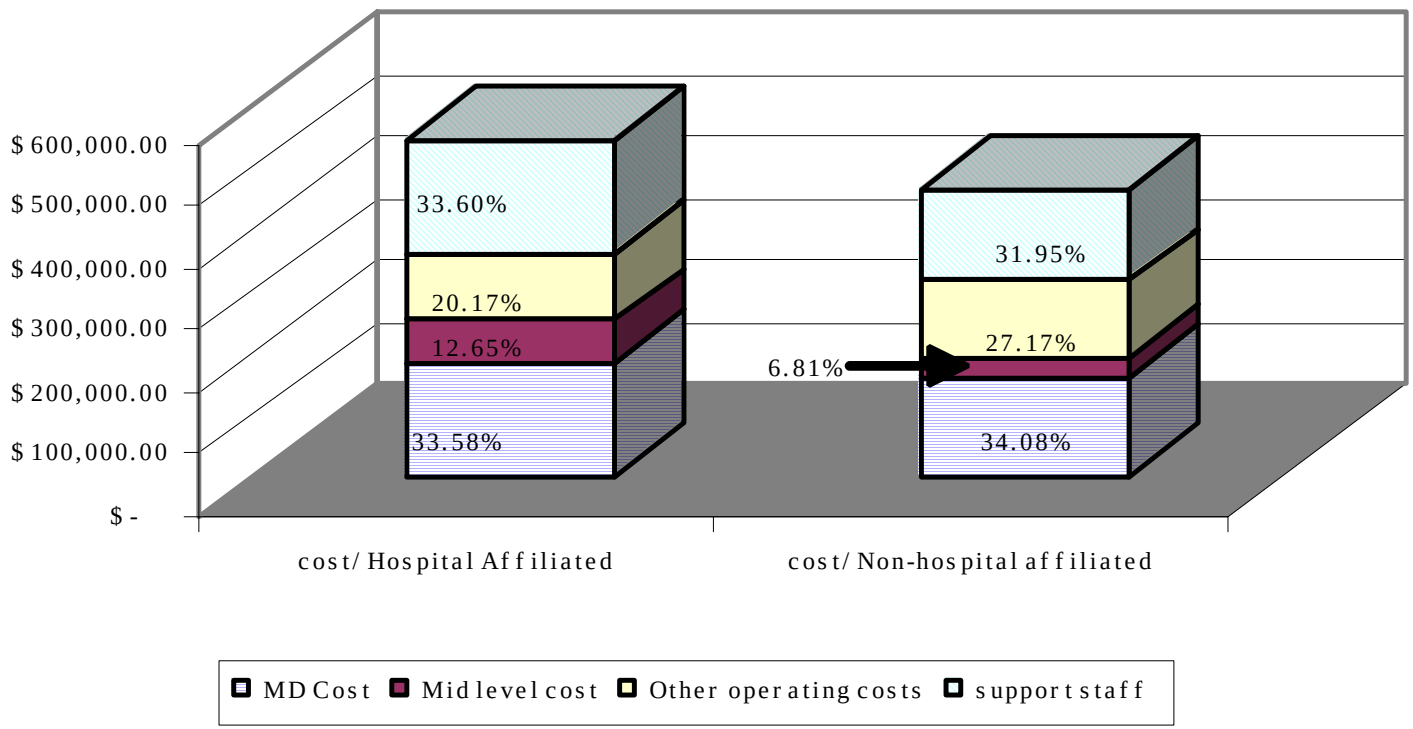
VARIATION AMONG RHCs BY KEY CHARACTERISTICS OF THE RHCs

- Hospital affiliated and non-hospital affiliated
- Location
- Length of time as an RHC
- Clinic size by # of doctors

KEY DIFFERENCES BETWEEN HOSPITAL AFFILIATED AND NON-HOSPITAL AFFILIATED RHCs

- Hospital owned clinics are smaller and generate 50% less revenues
- Non-hospital owned RHCs saw 21% Medicaid vs. 16% for hospital owned
- Operating cost/visit was 10% higher in the hospital owned clinics
- The median hospital owned clinic lost $51,390/MD FTE
- Hospital owned tended to operate in more remote areas

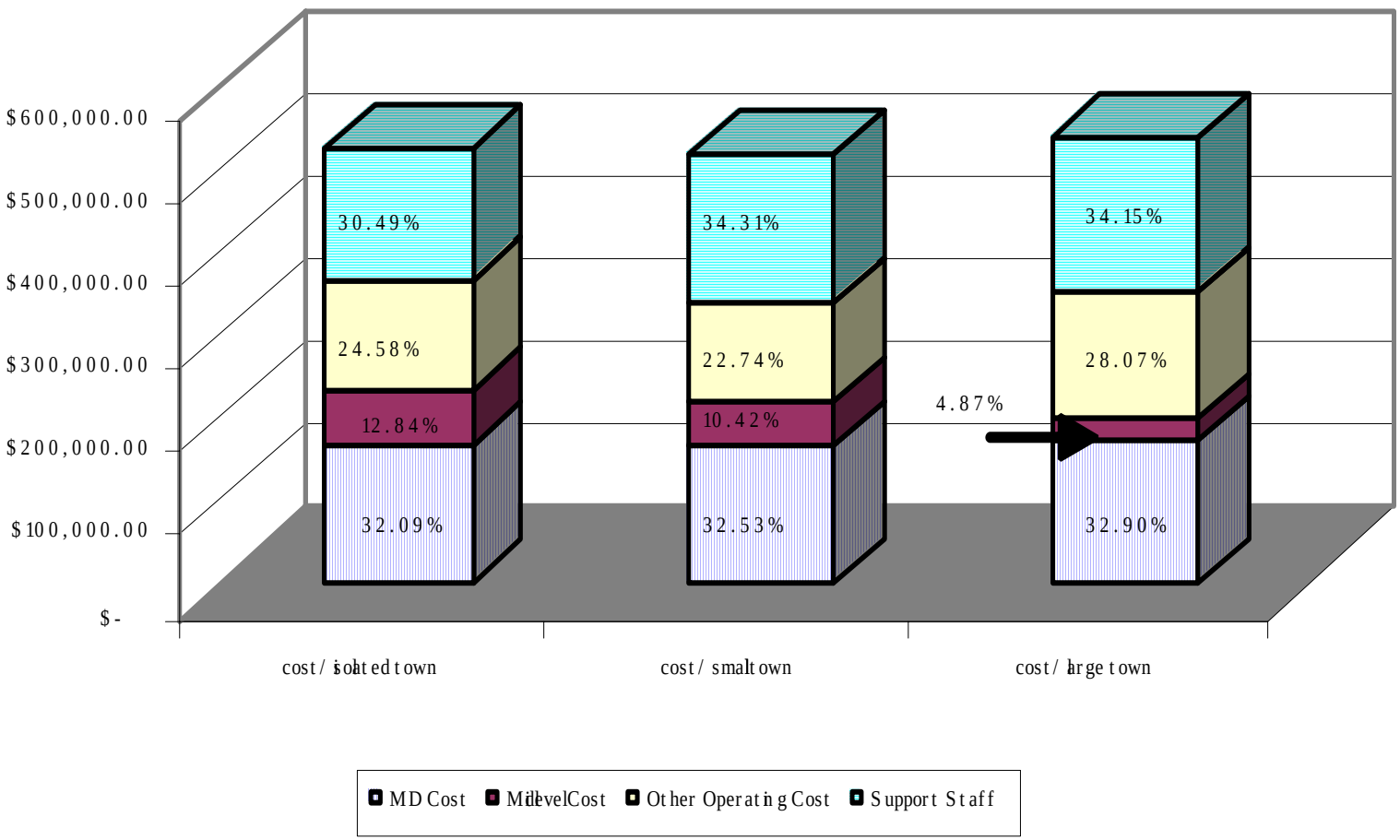
Cost Structure between RHCs by Hospital Affiliated vs. Non-hospital affiliated



KEY DIFFERENCES BY LOCATION CHARACTERISTICS

- Large town clinics were bigger and did more visits
- Proportions of Medicare and Medicaid were generally inversely proportional to community size
- Clinics in isolated areas had less revenue/visit but were about average in expense/visit
- The smaller the community the more difficult to operate the RHC

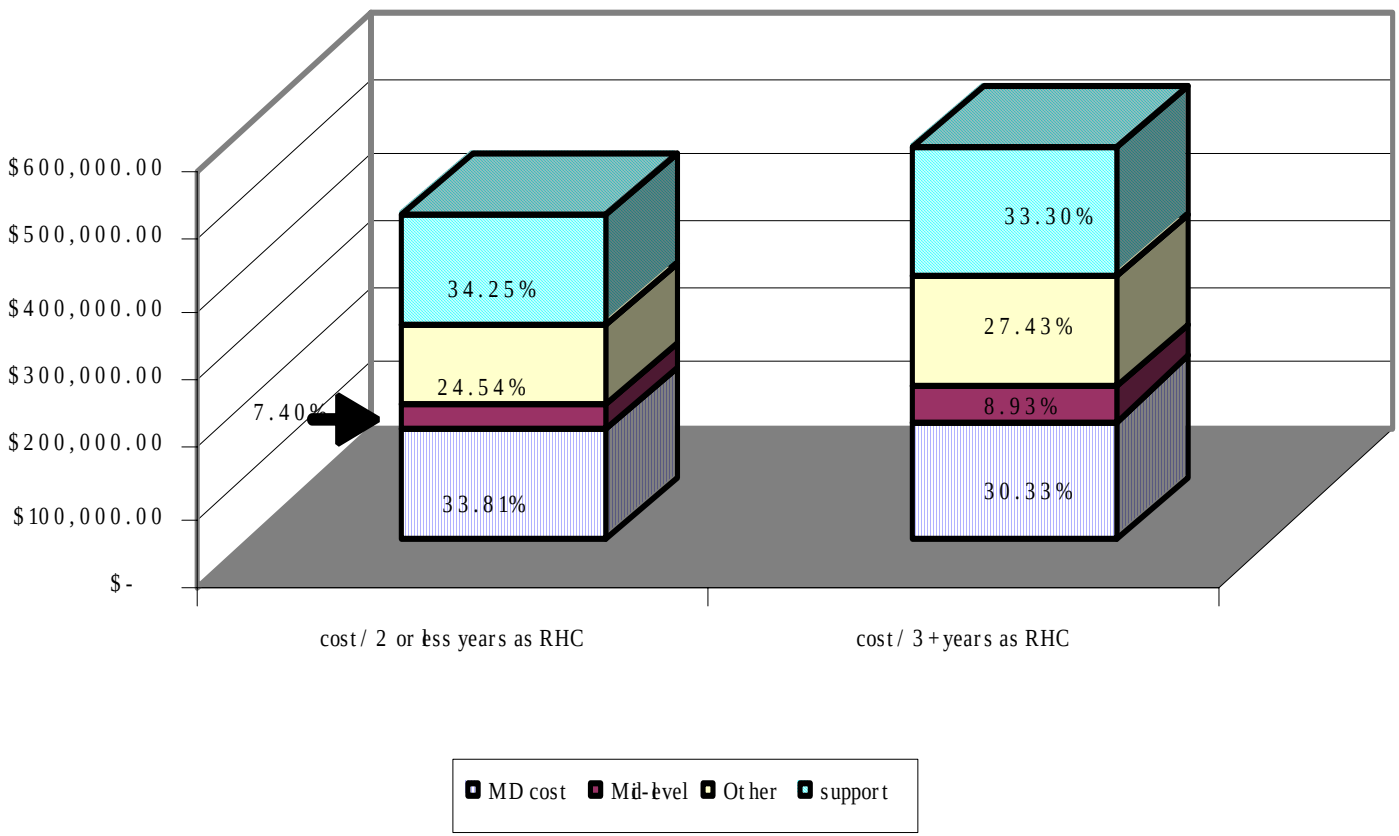
Cost Structure between RHCs by Location



KEY DIFFERENCES BY LENGTH OF TIME AS AN RHC

- Length of time as an RHC correlated to better financial performance
- “Older” RHCs generate 21% more revenue per MD

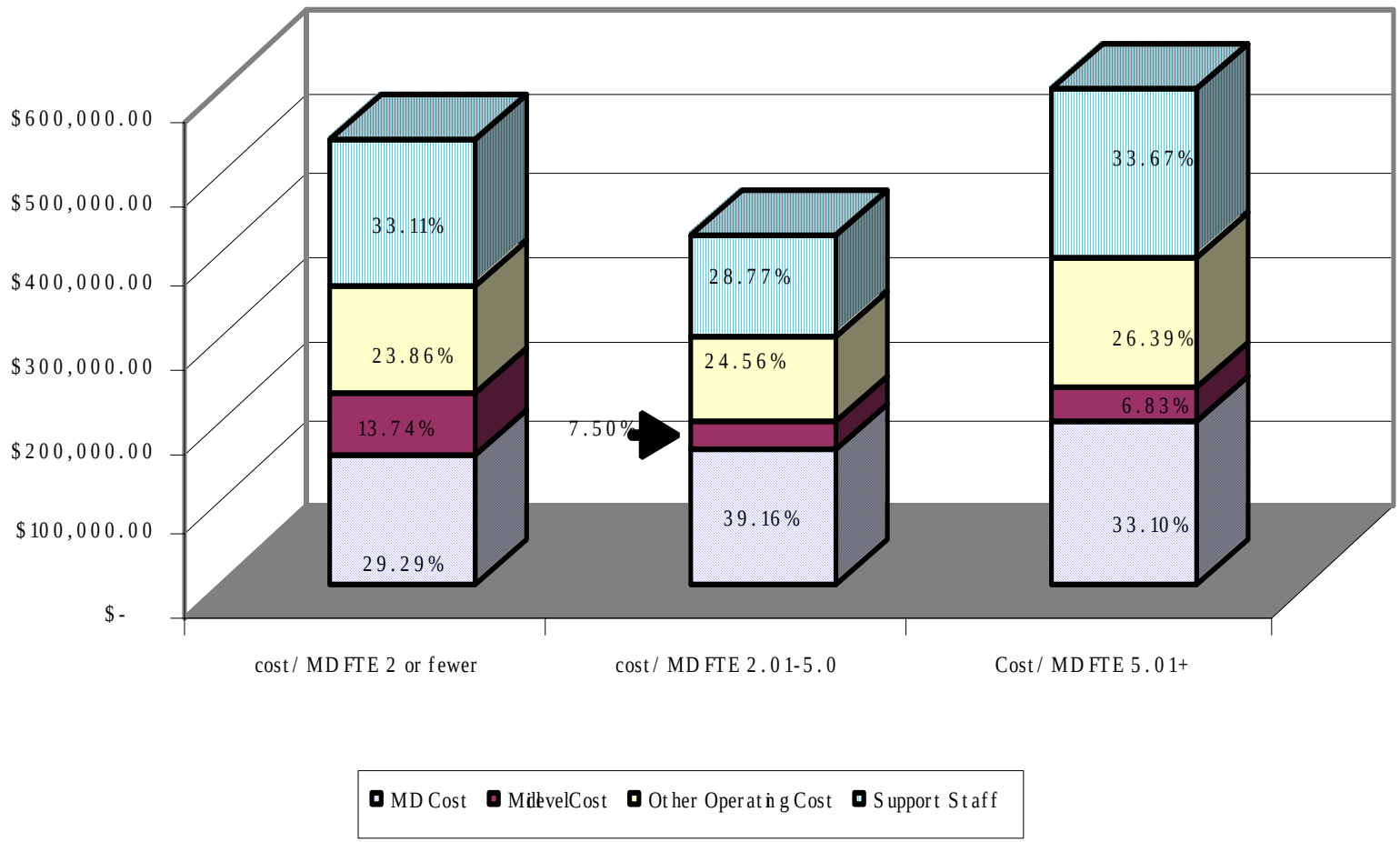
Cost Structure between RHCs by 2-years vs. 3+ years



KEY DIFFERENCES BY CLINIC SIZE

- Size group were: less than 2.0; 2.01-5.0; and 5.01+
- Small clinics saw more visits/MD FTE, due to greater use of Mid-levels
- Less revenue/visit (about 28%) was the main cause of poorer financial performance in the smaller clinics
- Compensation/MD was much lower in the smallest clinics
- Small clinics were the only group to have a median operating loss
- Building and occupancy as a percent of total cost was inversely proportional to clinic size.

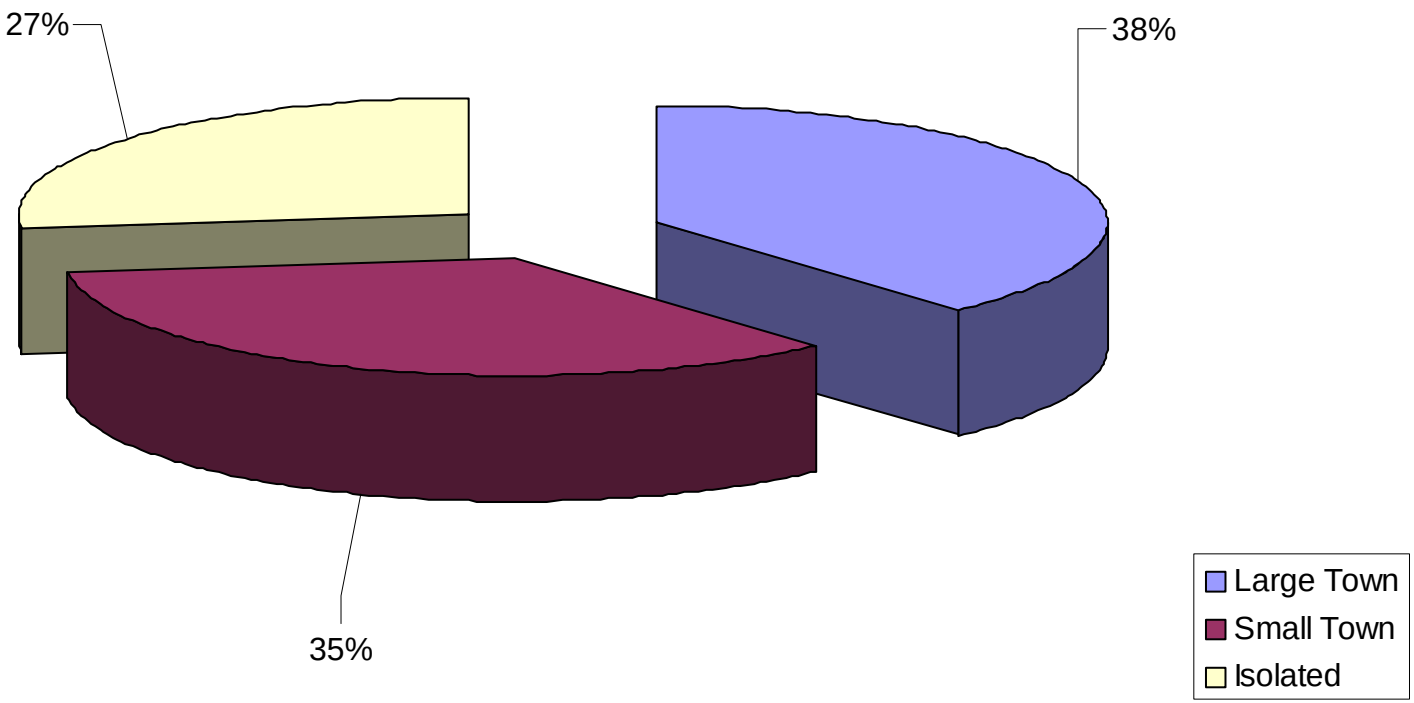
Cost Structure Differences between RHCs by Number of MDs FTE



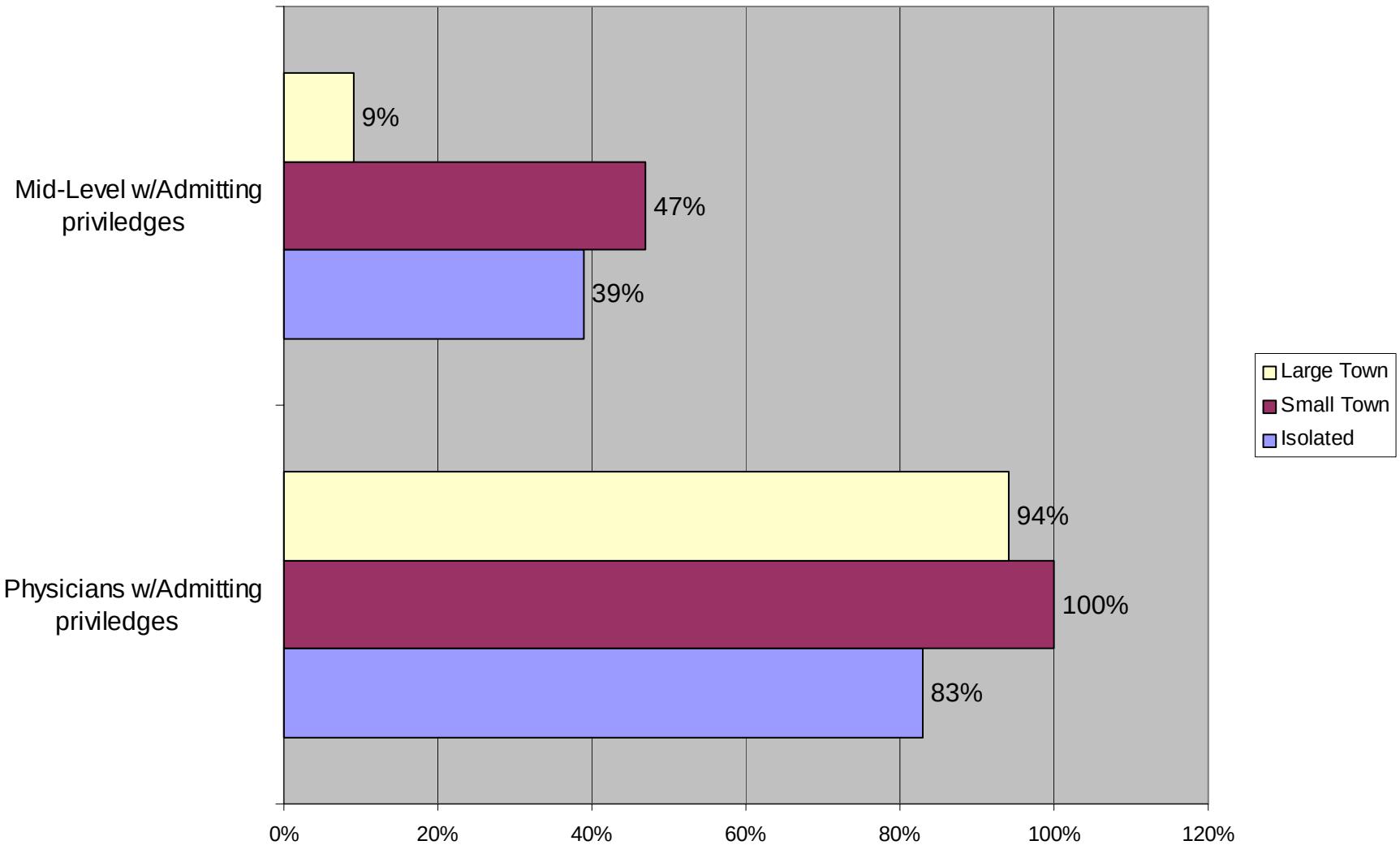
Part II – Qualitative Report

- Hospital Call & Hospital Privileges
- Recruitment Issues
- Days and Hours of Operation of RHCs
- Clinician Satisfaction Factors
- Clinician Length of Service
- Staffing Patterns

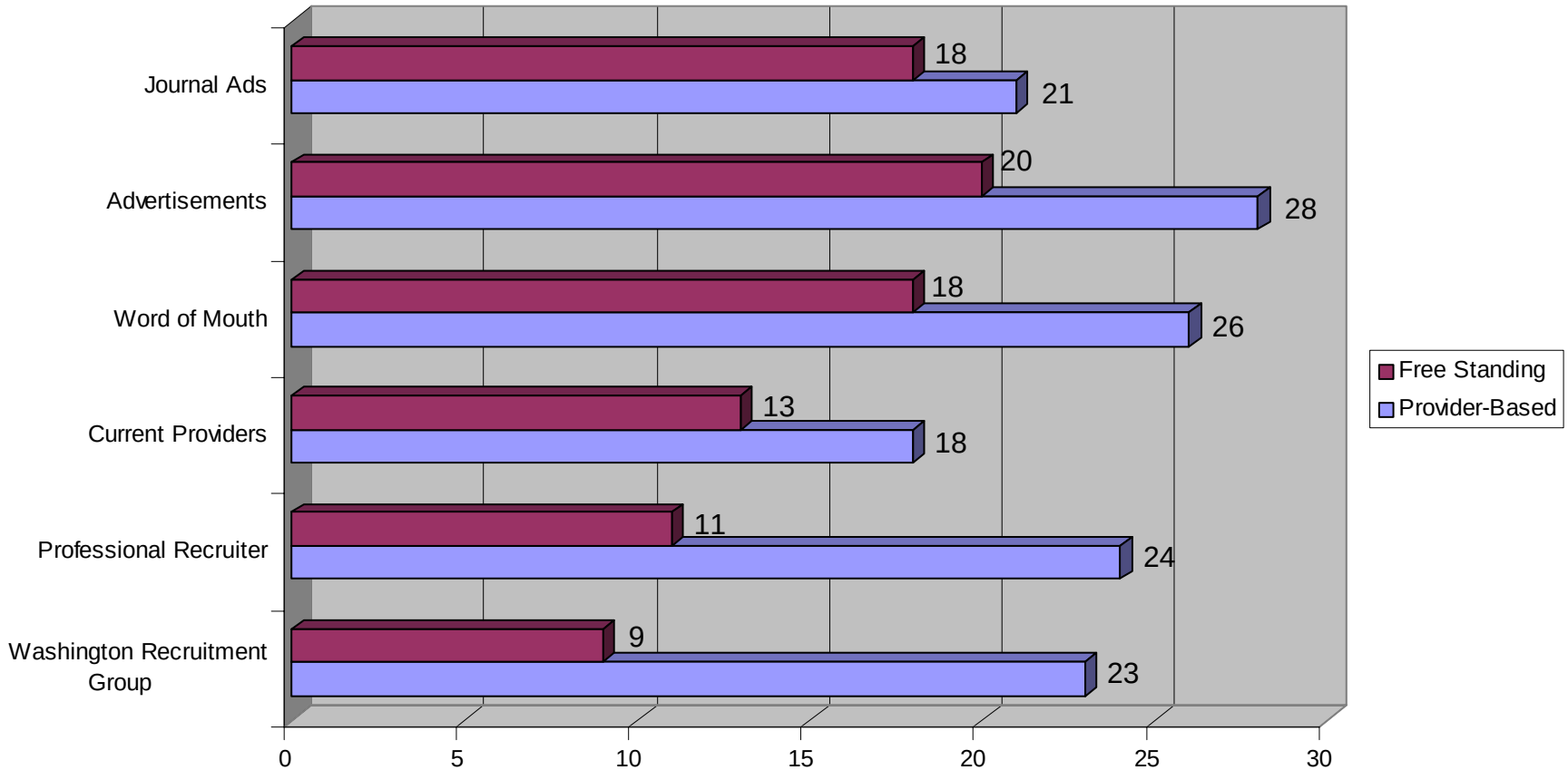
Clinics with Clinicians Taking Hospital Call



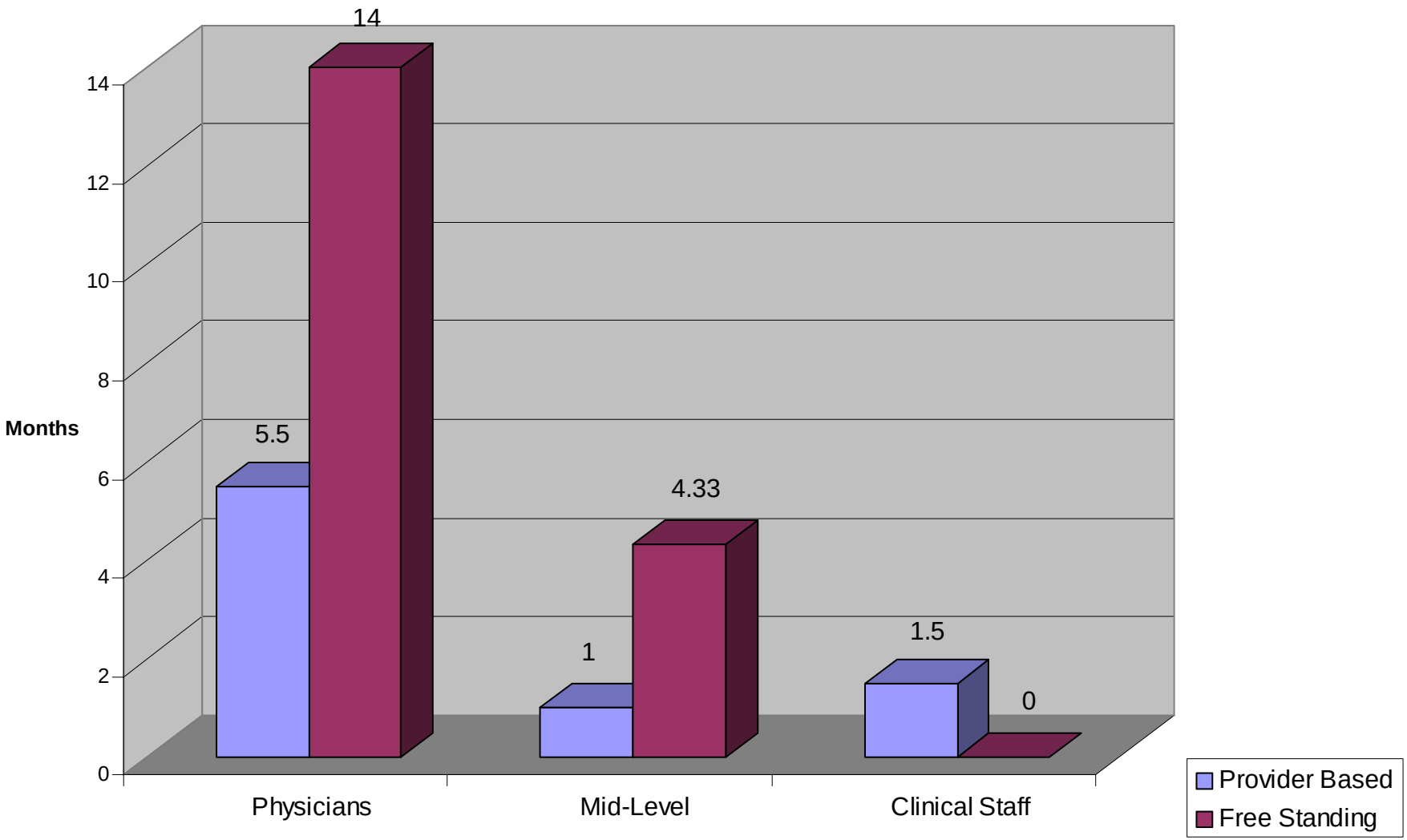
Clinicians with Hospital Admitting Privileges



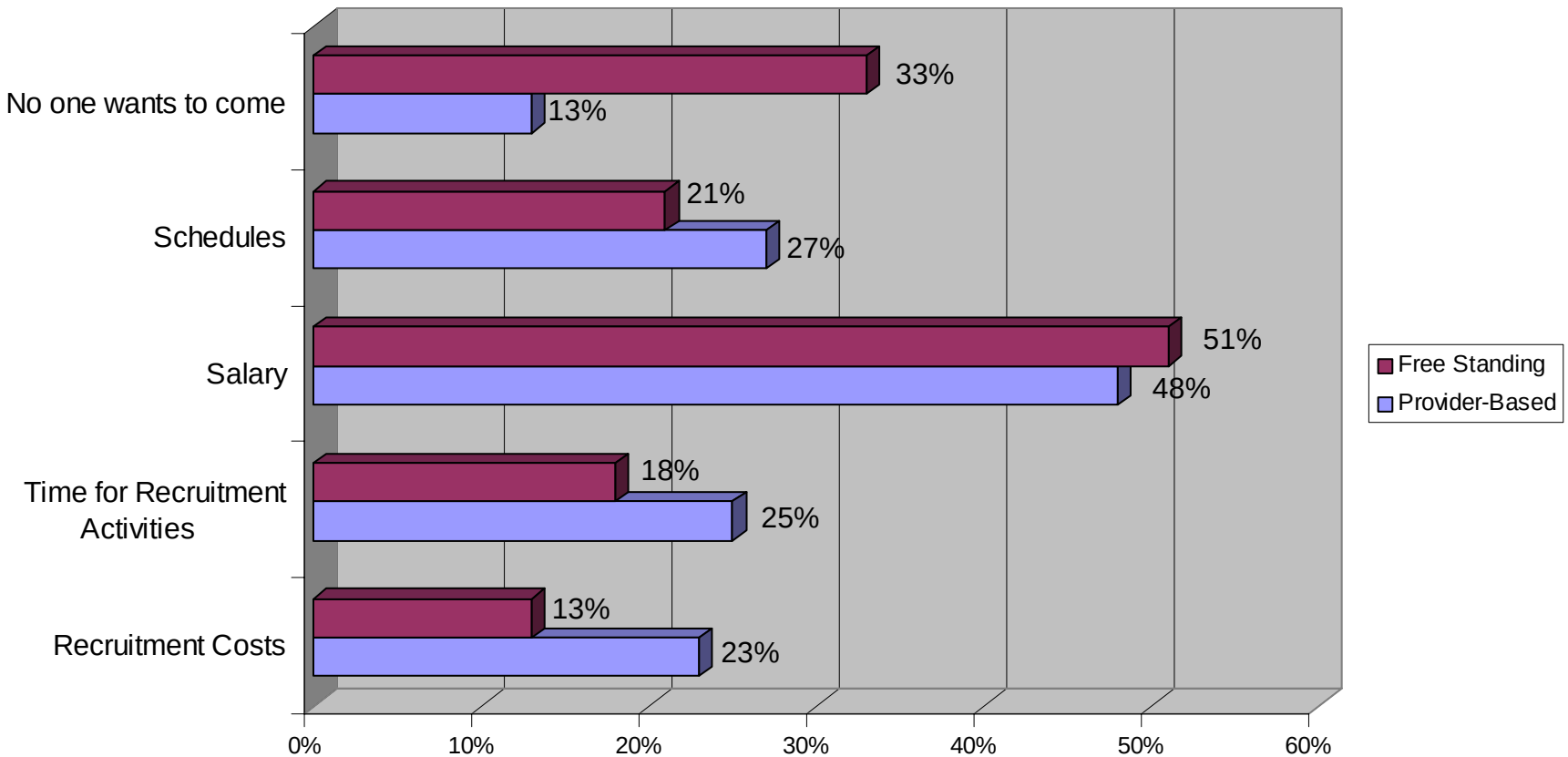
Recruitment Methods - Professionals



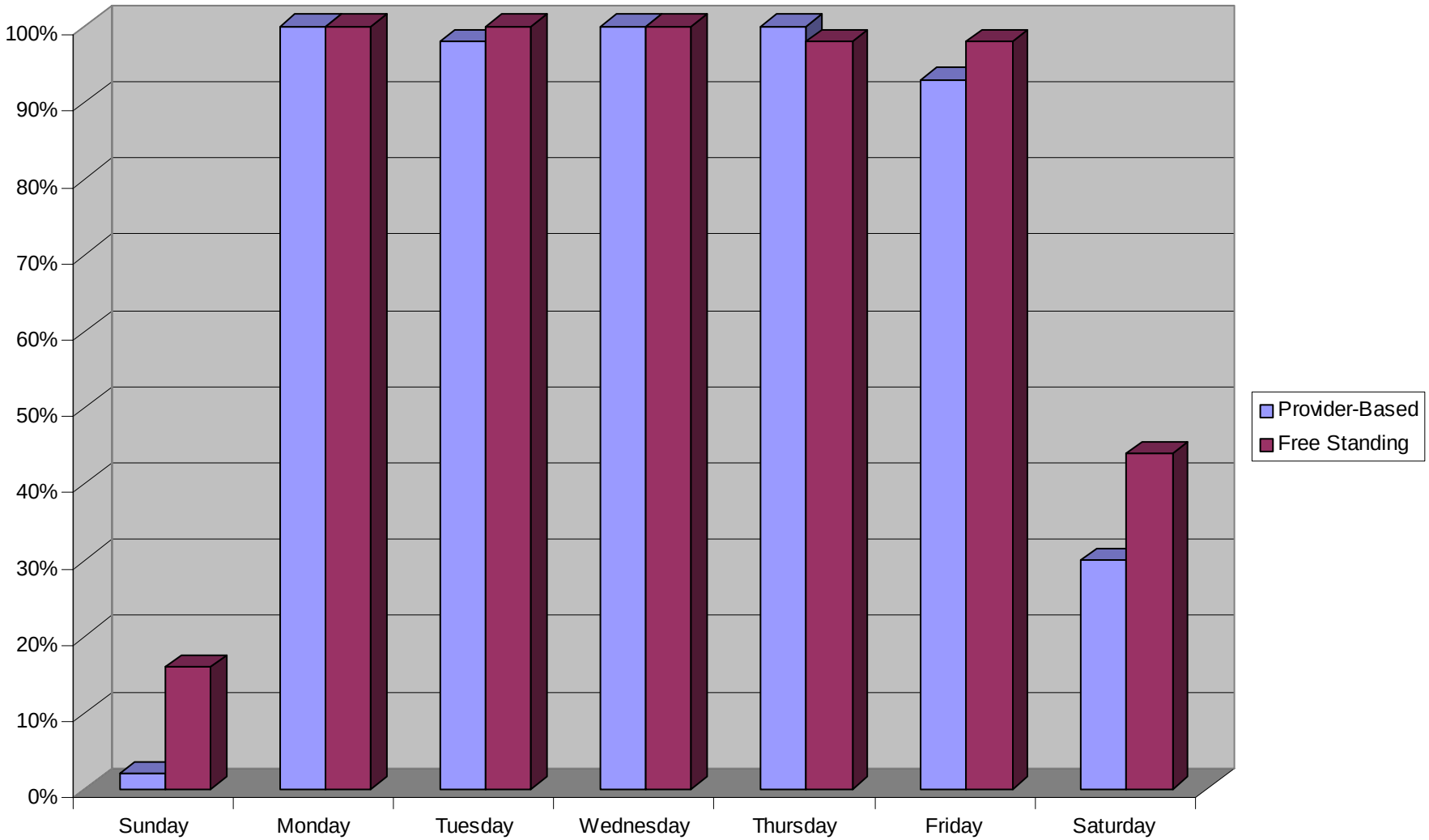
Average Length of Vacancies



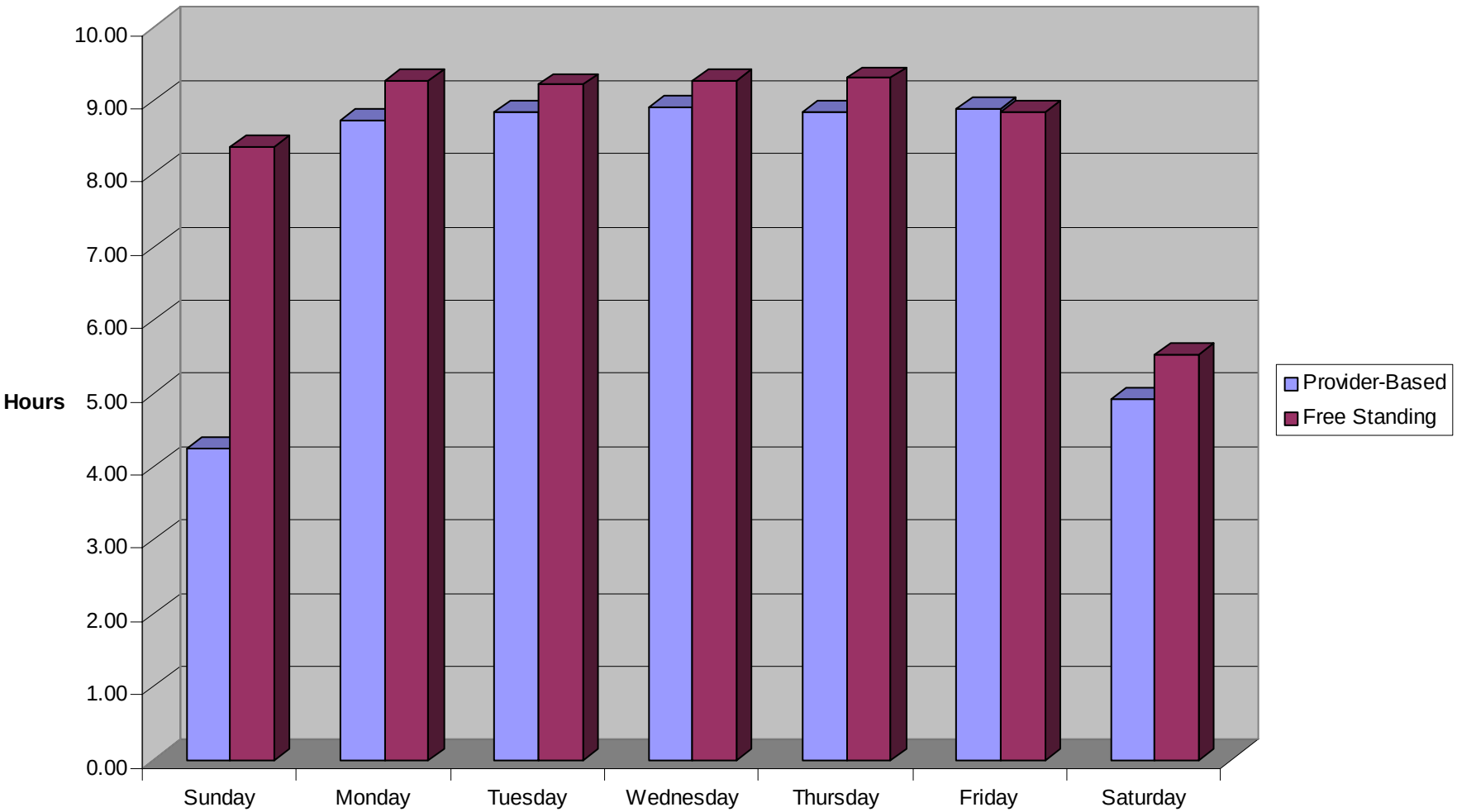
Barriers to Recruitment



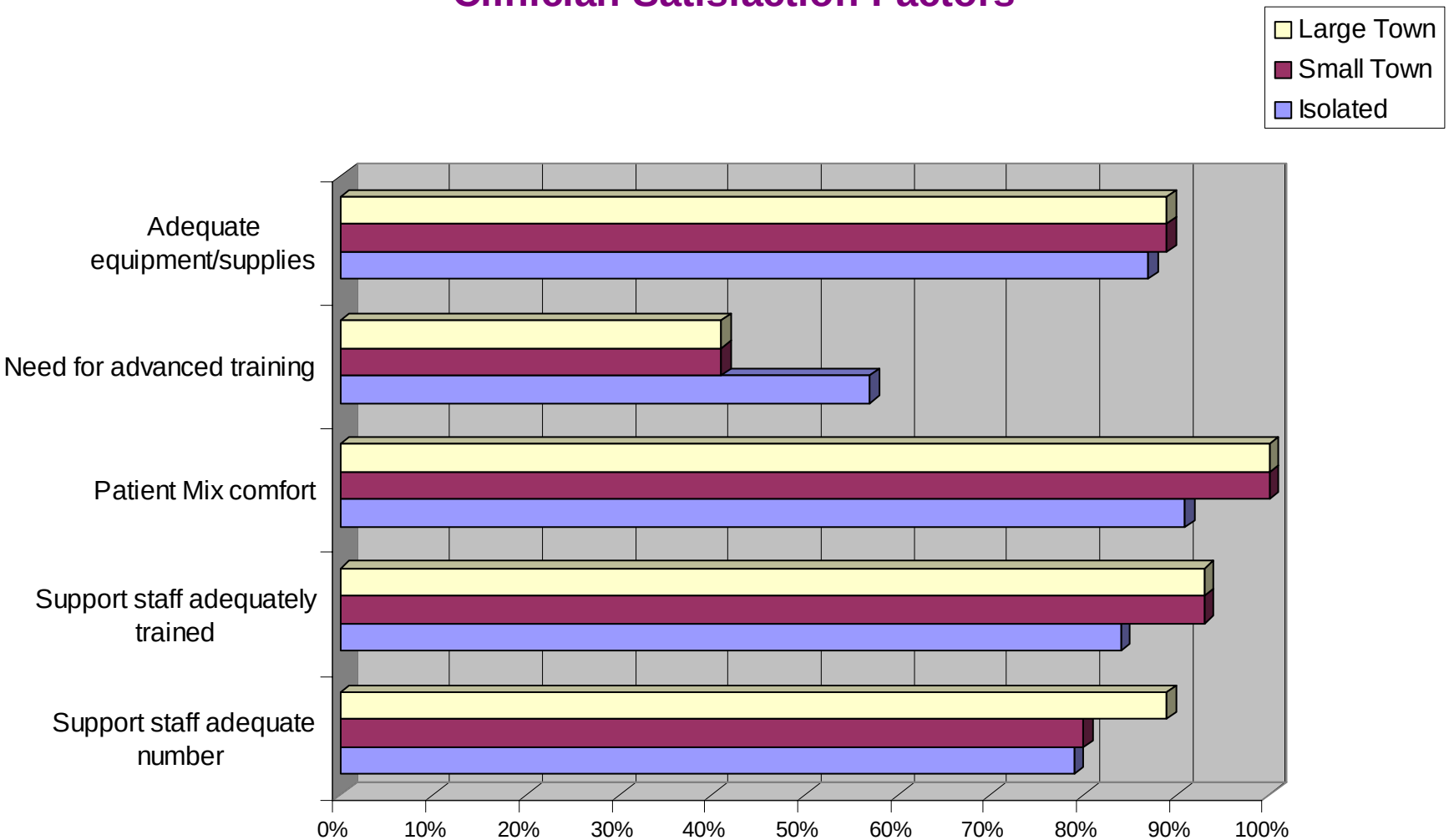
RHC Days of Operation



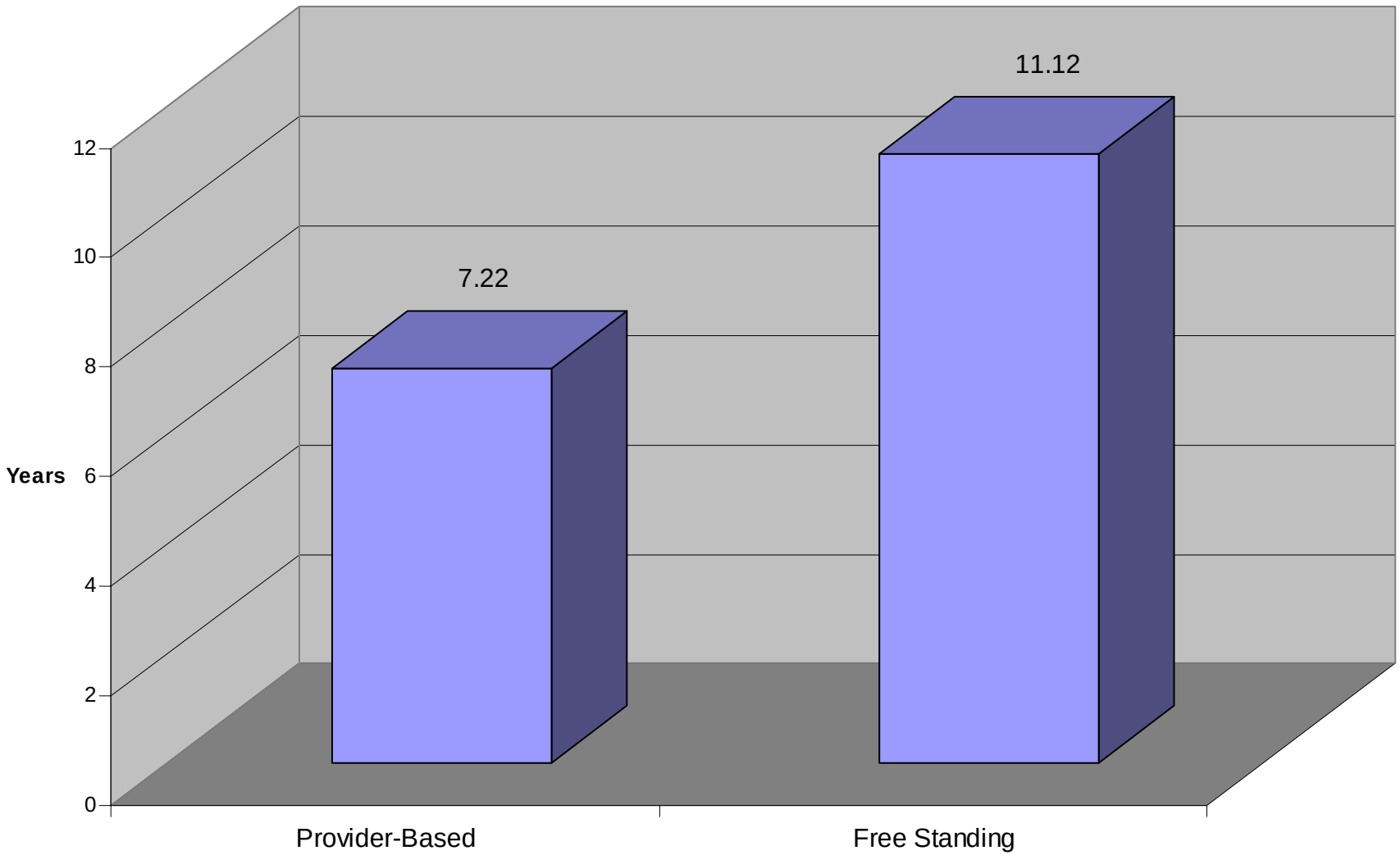
RHC Average Hours of Operation



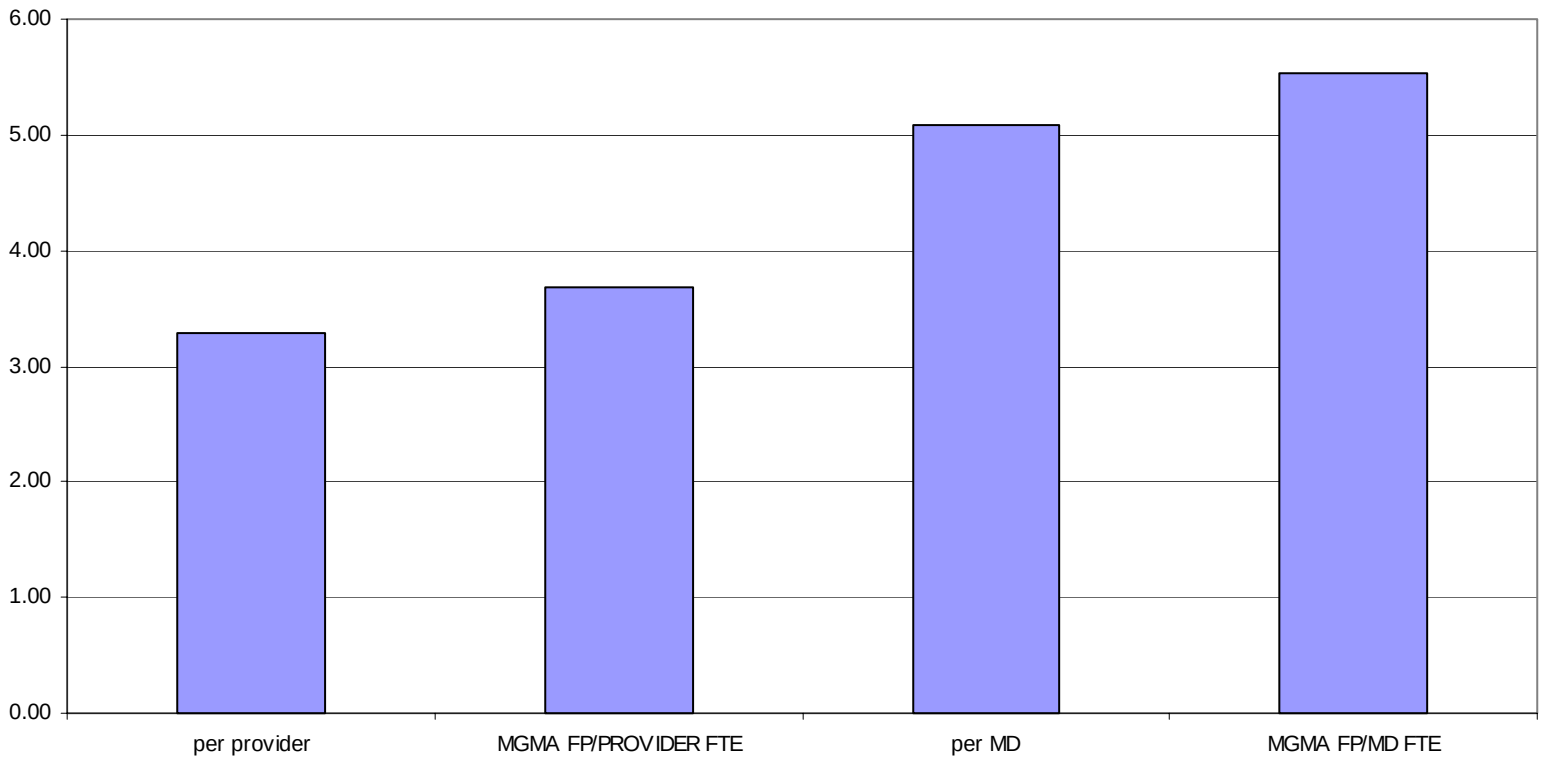
Clinician Satisfaction Factors



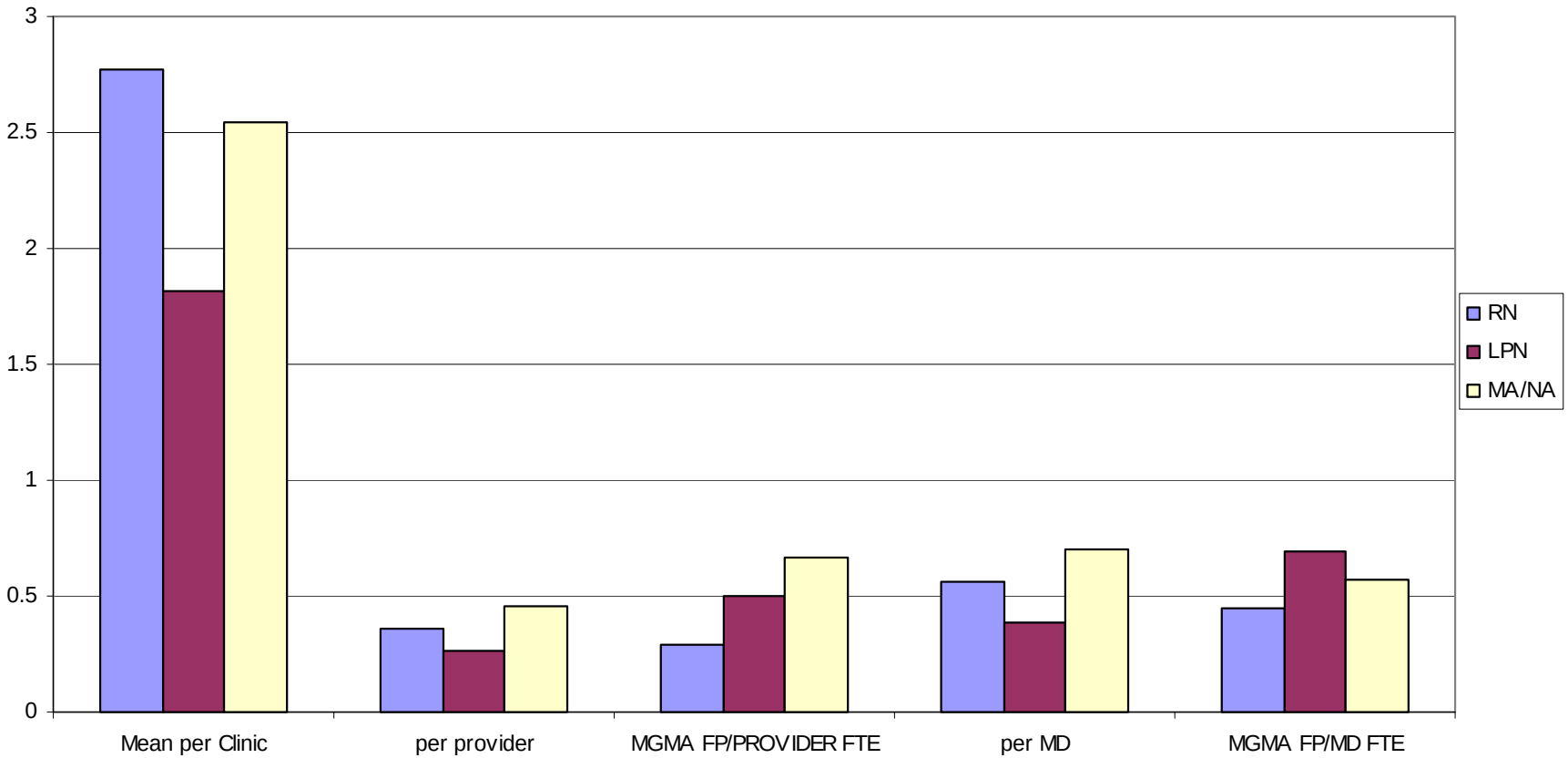
Clinician Average Length of Service



Total Support Staff



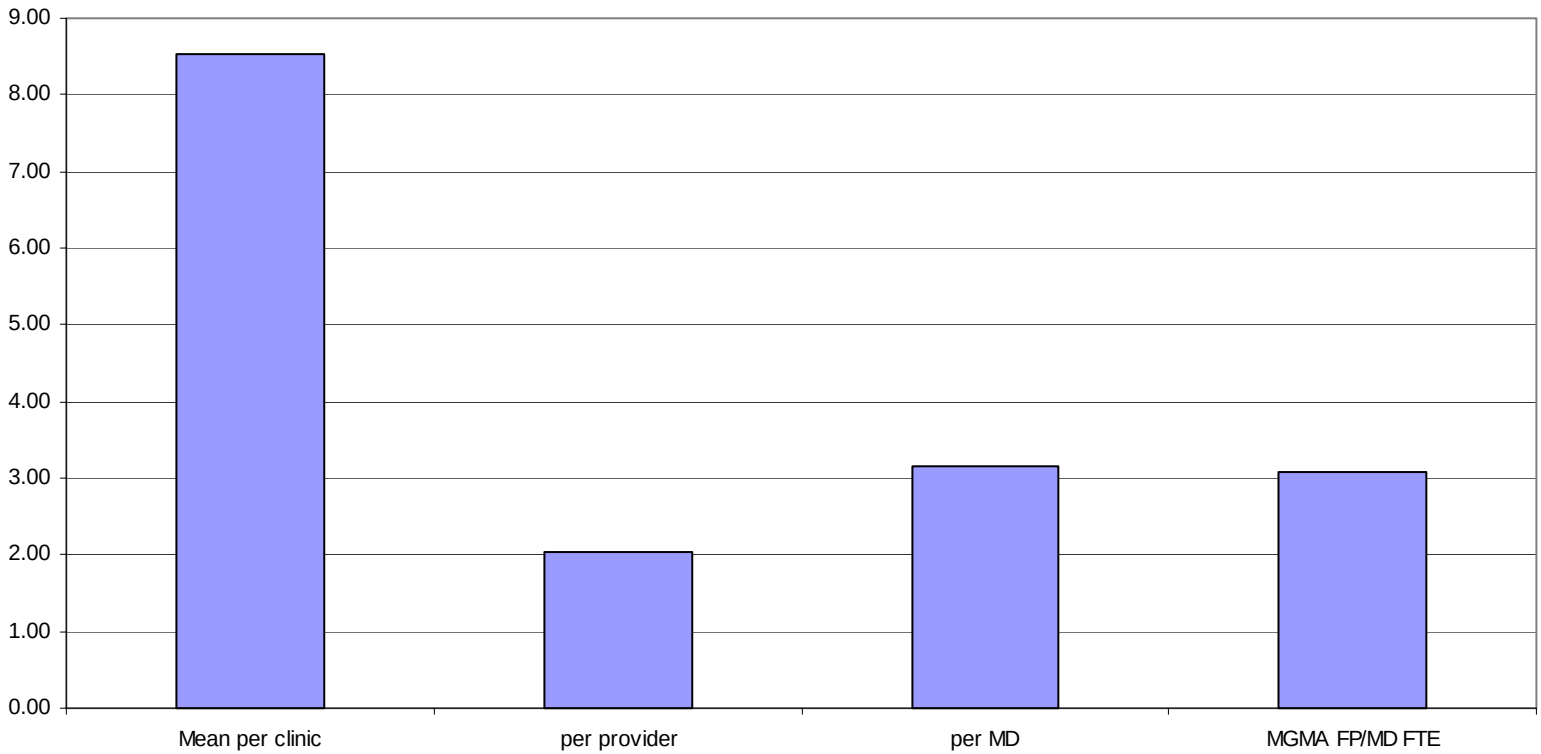
Nursing Staff



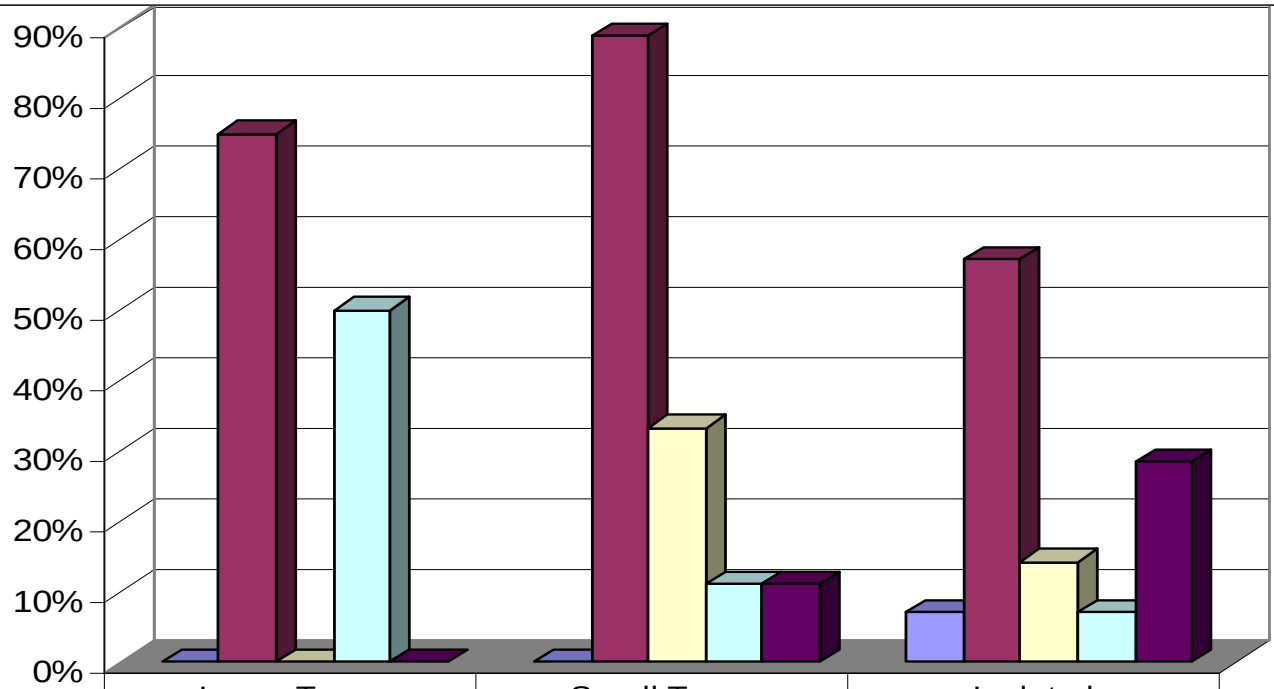
Highlights - RHC Access

- 98% are accepting new Medicare
- 99% are accepting new Medicaid
- 33% indicated RHC had changed payer mix
  - 38% significantly more Medicare
  - 41% significantly more Medicaid
  - 2% more commercial insurance
  - 24% significantly better Uninsured Access

Total Non-Clinical Support Staff

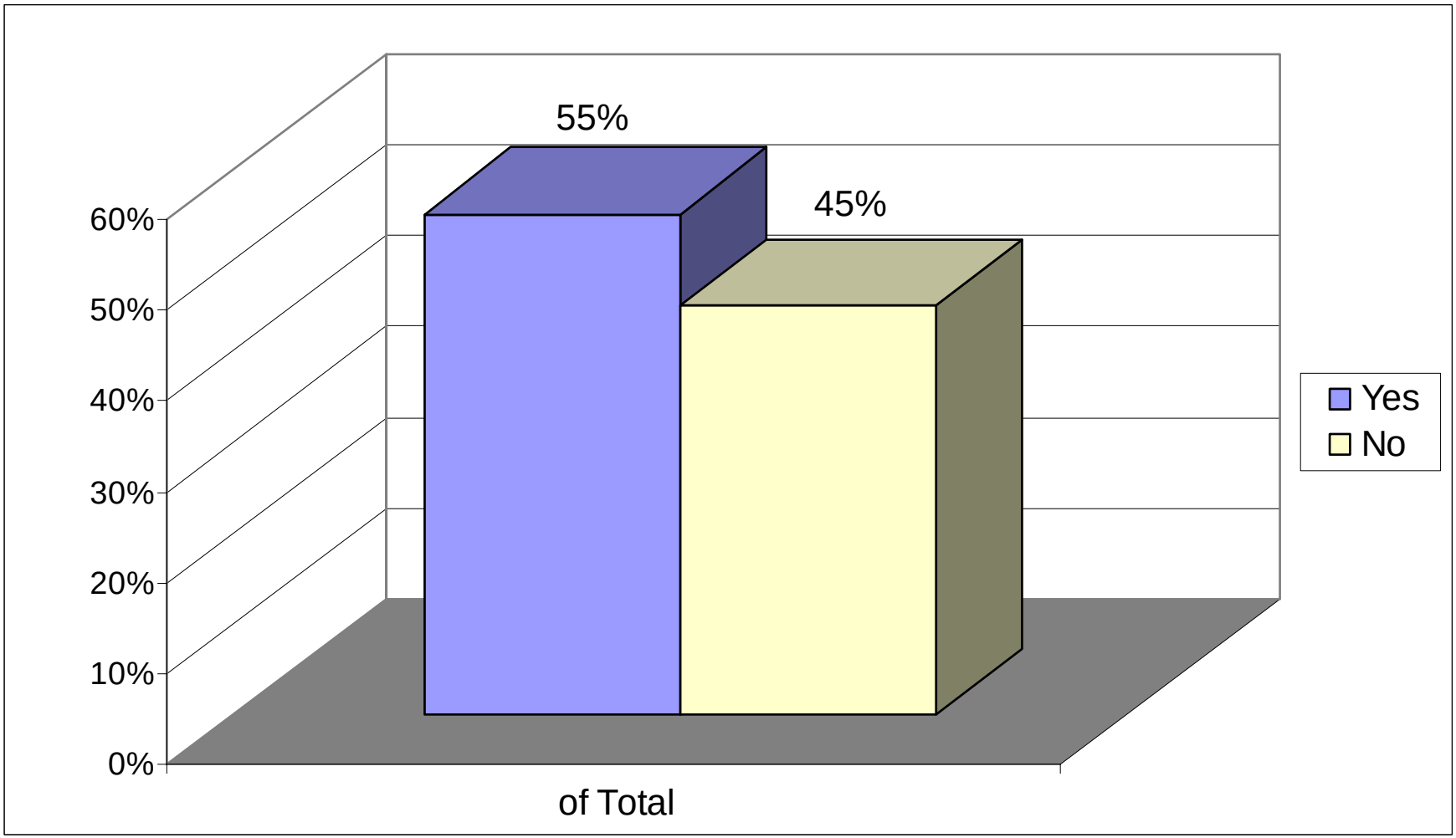


Improvements for Access

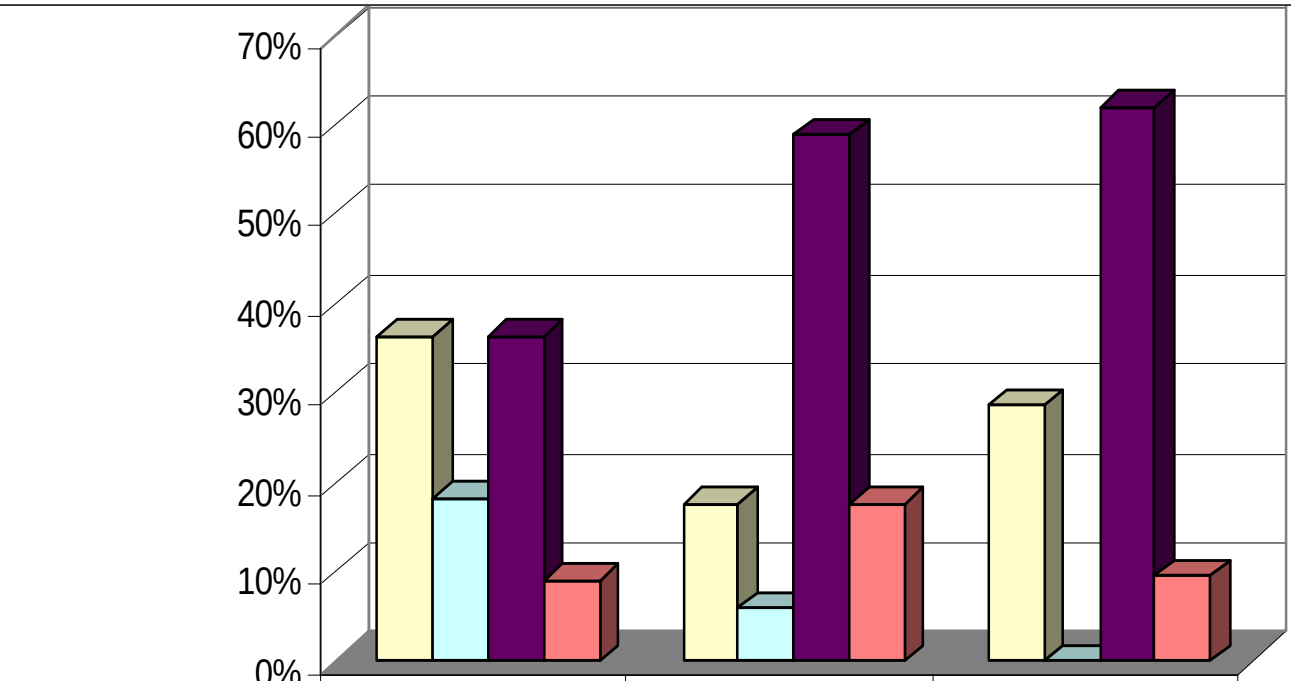


	Large Town	Small Town	Isolated
Not exist	0%	0%	7%
Greater Uninsured Access	75%	89%	57%
Adopted SFS	0%	33%	14%
Medicare & Caid Access	50%	11%	7%
Always Served Uninsured	0%	11%	29%

% of RHCs with Sliding Fee Scale



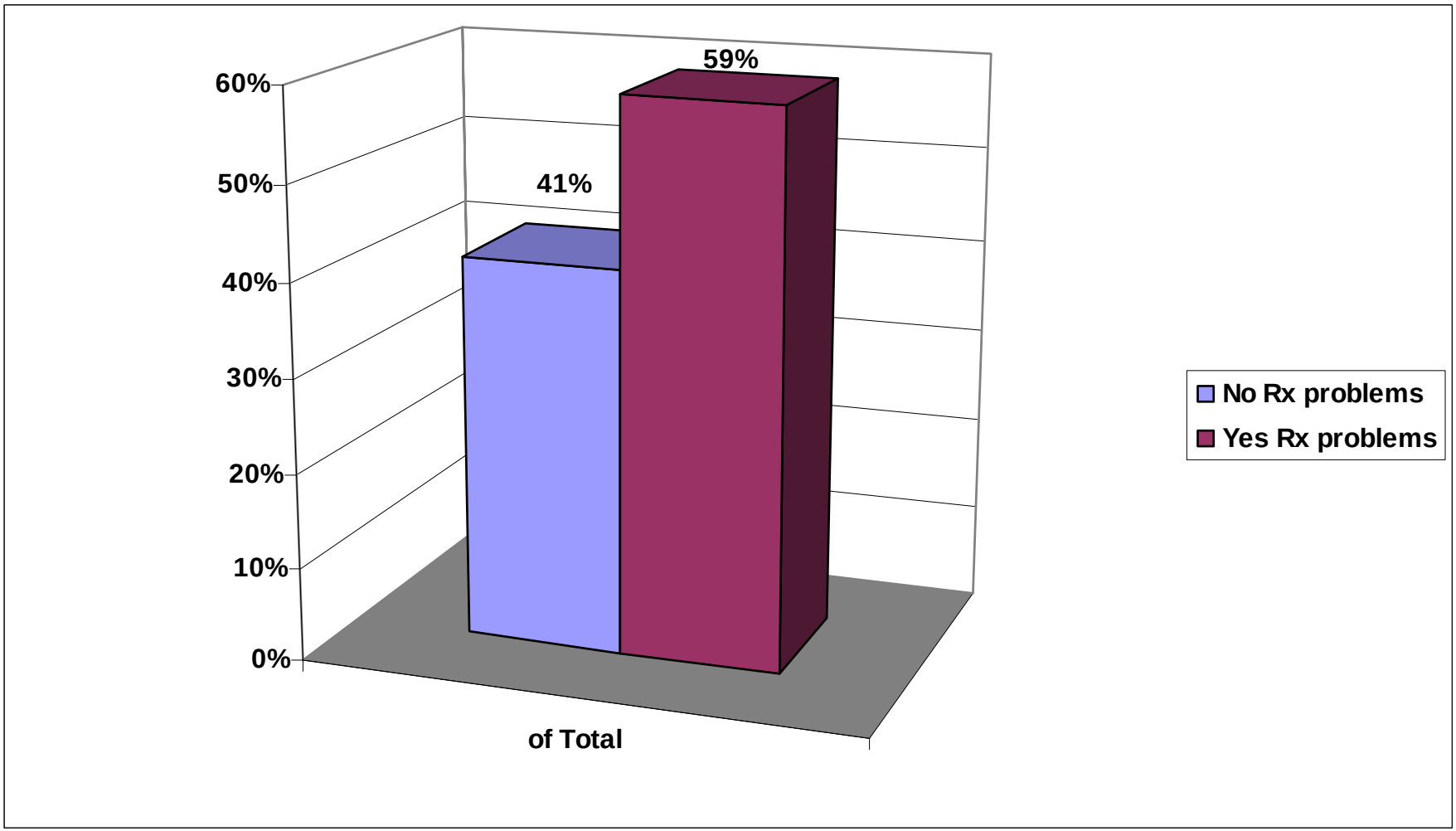
Location of Sliding Fee Scale



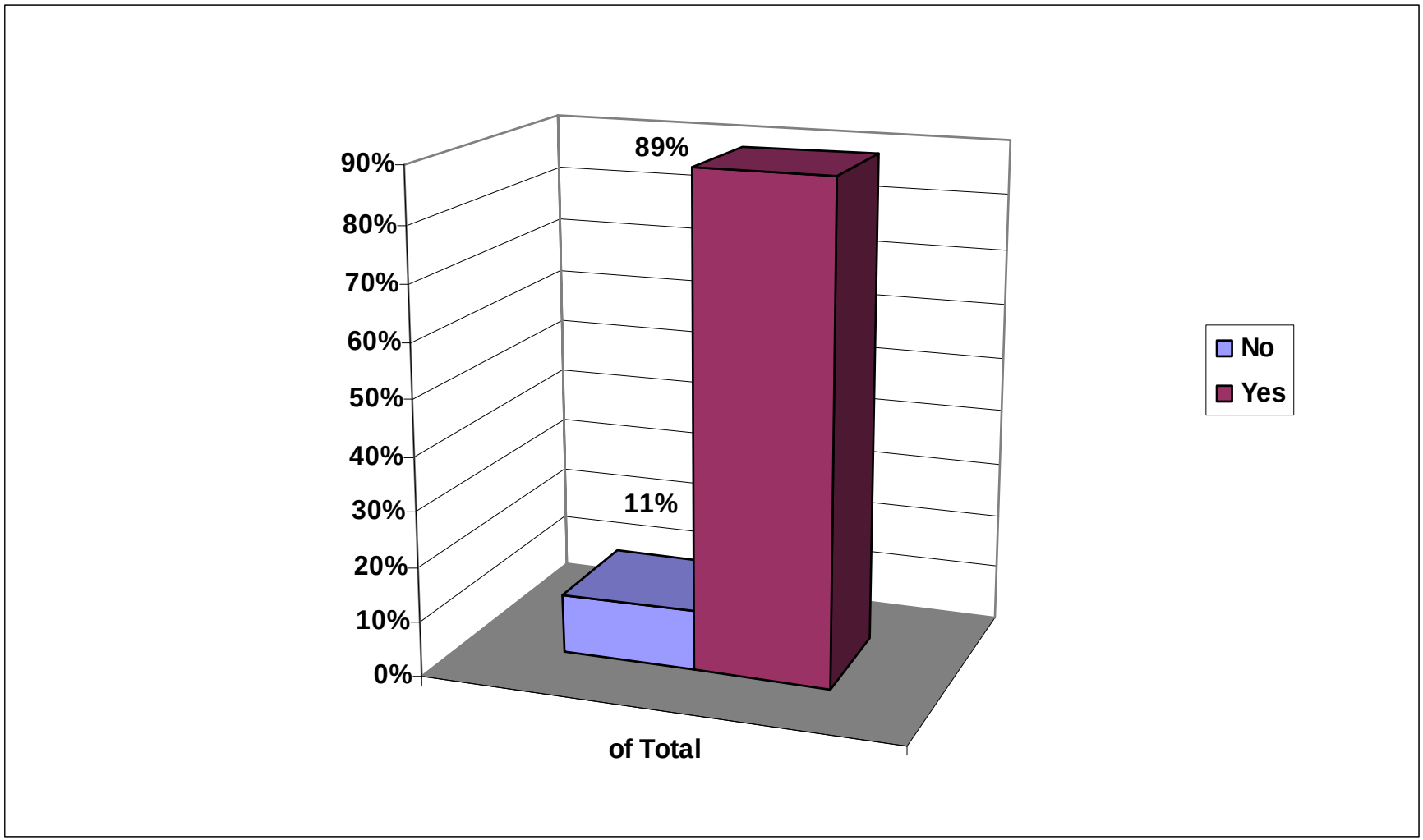
	Large Town	Small Town	Isolated
Not Posted	36%	18%	29%
J1 Area Only	18%	6%	0%
Reception Area	36%	59%	62%
Have Scale / NA	9%	18%	10%

RUCA

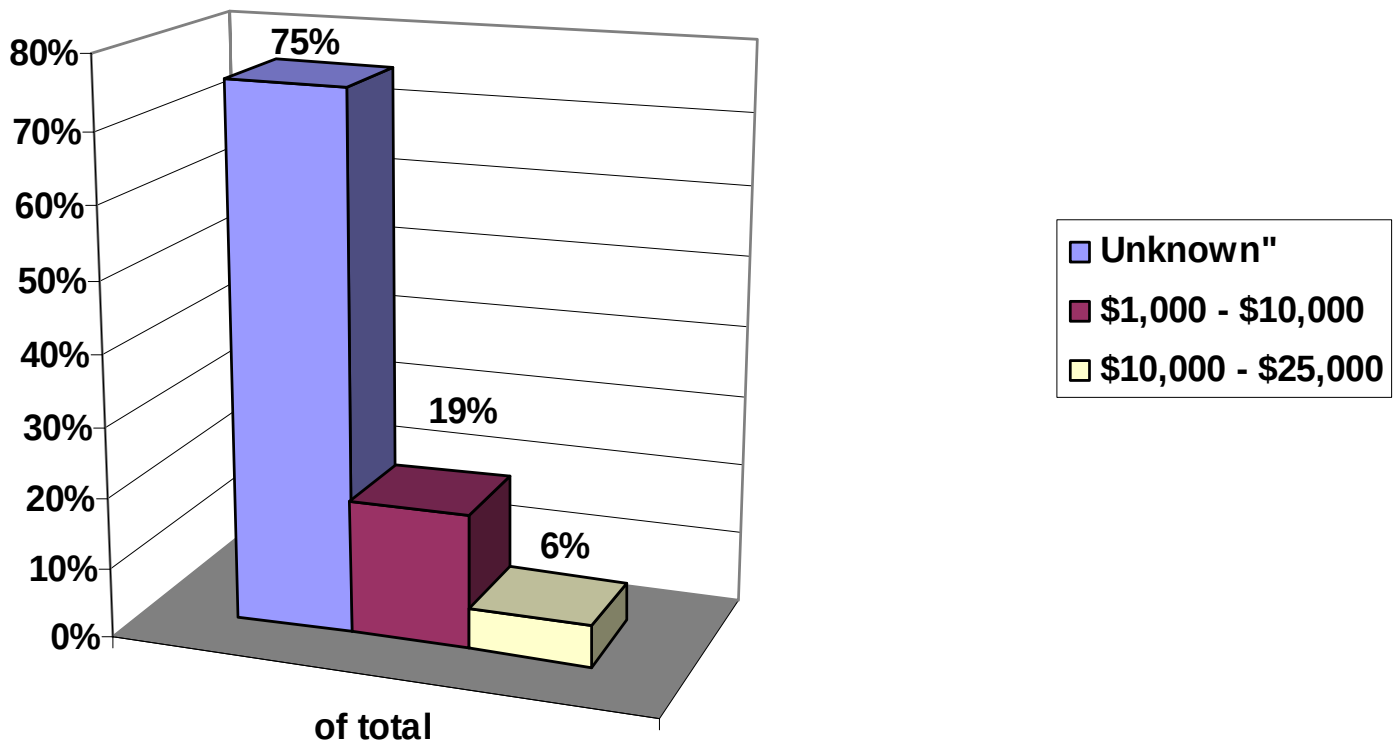
Patients Experience Rx Difficulties



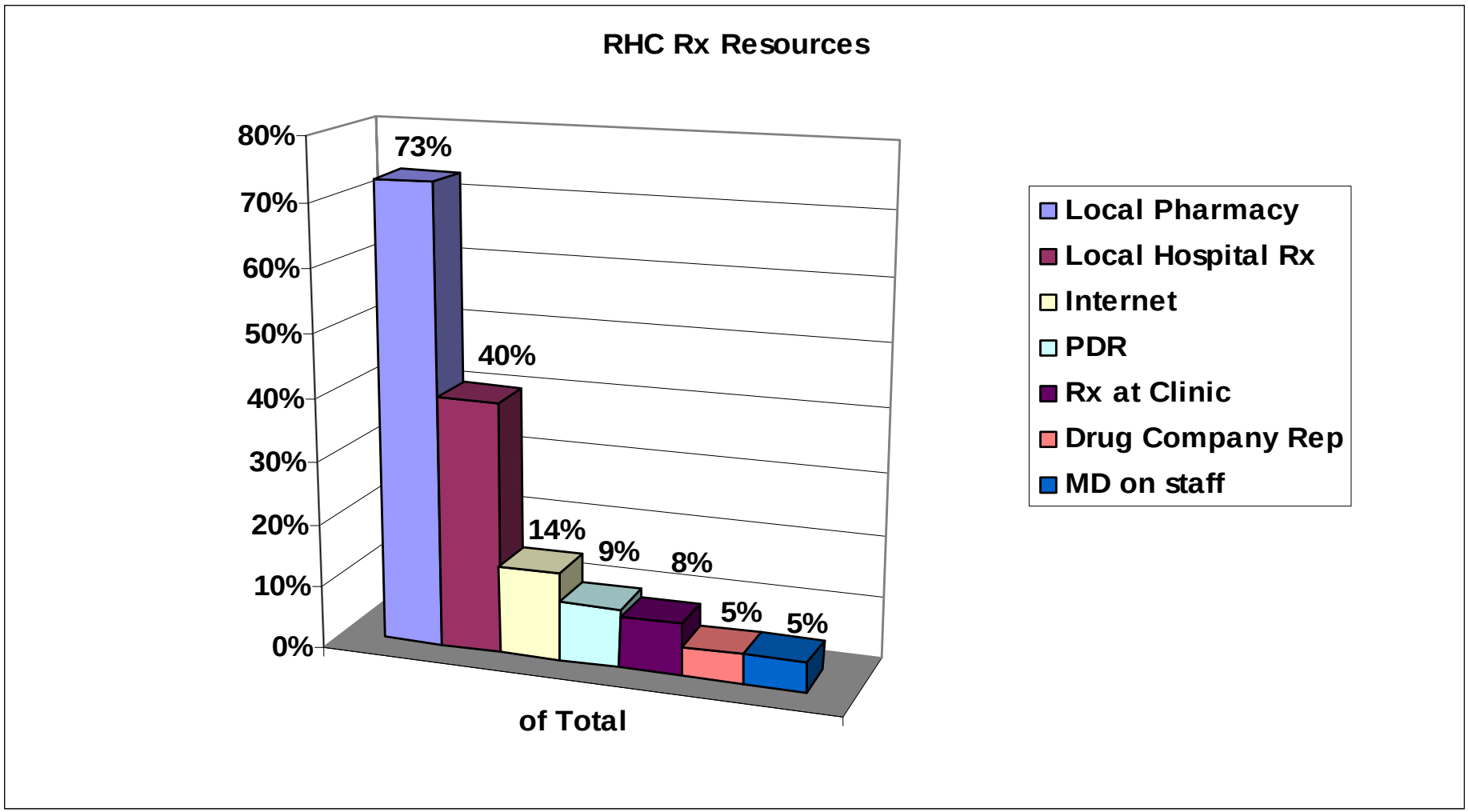
Free Medication Programs



Value of Rx Programs



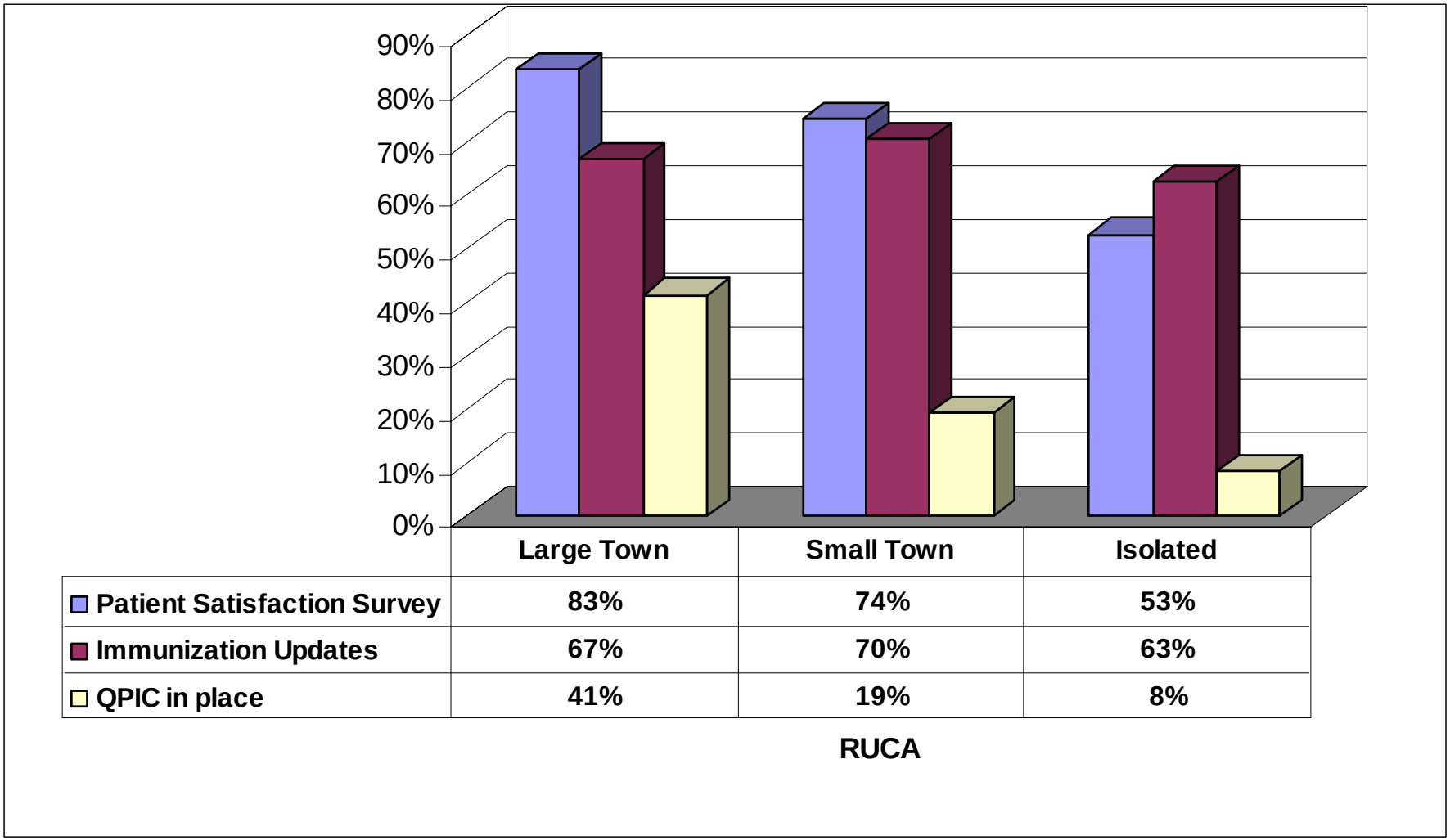
RHC Rx Resources



RHC Quality Measures

- Variety of formal and informal measures, indicators and processes.
- New Quality Assessment Performance Indicators will affect all clinics
  - How they implement Quality processes
  - How they track Quality processes
  - How they report Quality outcomes

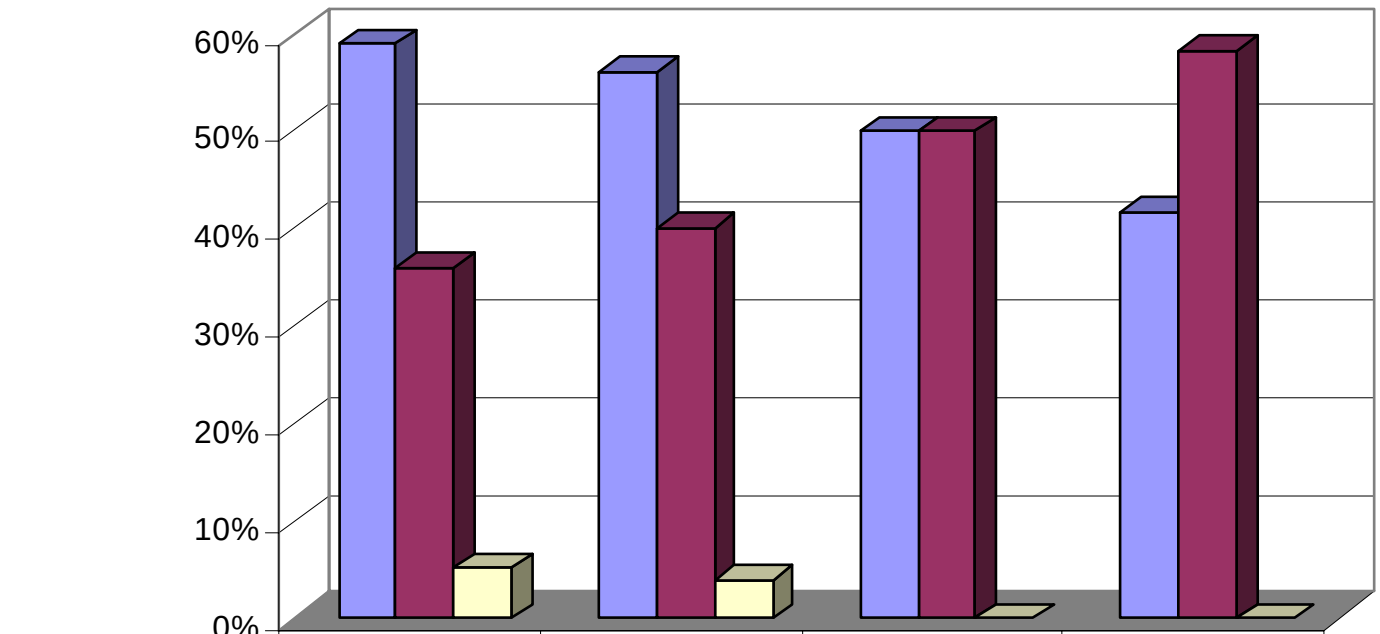
Quality Measures



	Large Town	Small Town	Isolated
Patient Satisfaction Survey	83%	74%	53%
Immunization Updates	67%	70%	63%
QPIC in place	41%	19%	8%

RUCA

Medical & RX Error Protocol

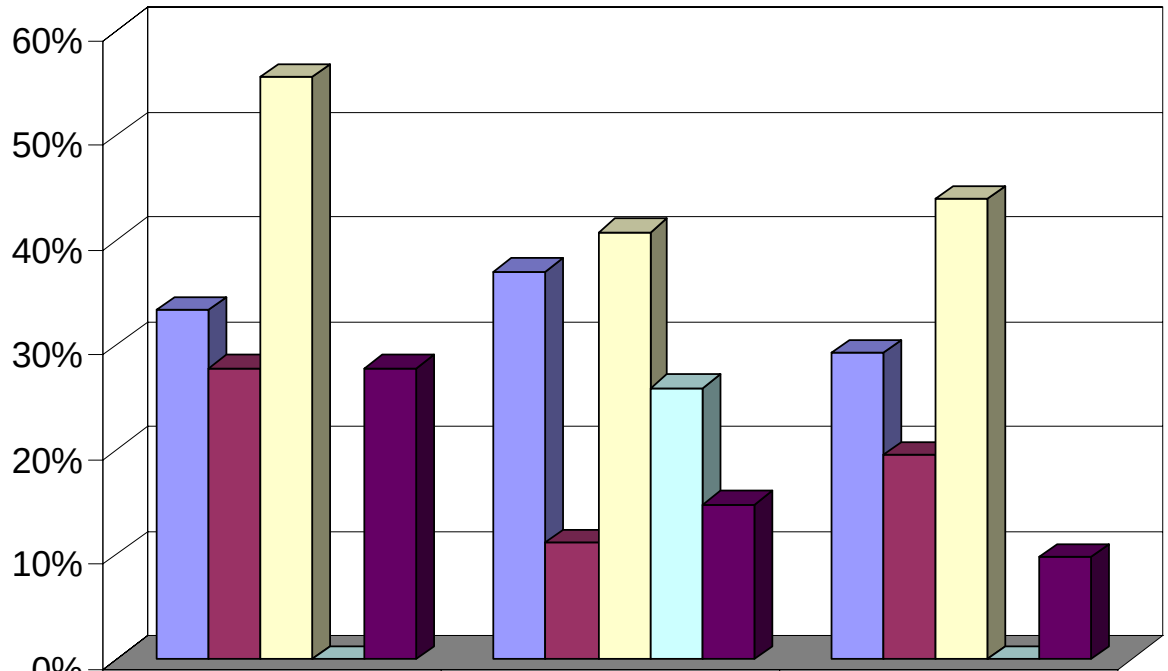


	2 or less	2.1-5	>5	N/A *
Most Stringent	59%	56%	50%	42%
Less Stringent	36%	40%	50%	58%
Not in Place	5%	4%	0%	0%

Clinic Size by MD FTE

- RHC Competitors
- Challenges for RHCs
- Benefits from RHC Certification

RHC Clinic Competition



	Large Town	Small Town	Isolated
None	33%	37%	29%
FQHC	28%	11%	20%
Other Local Providers	56%	41%	44%
Hospital	0%	26%	0%
Other RHCs	28%	15%	10%

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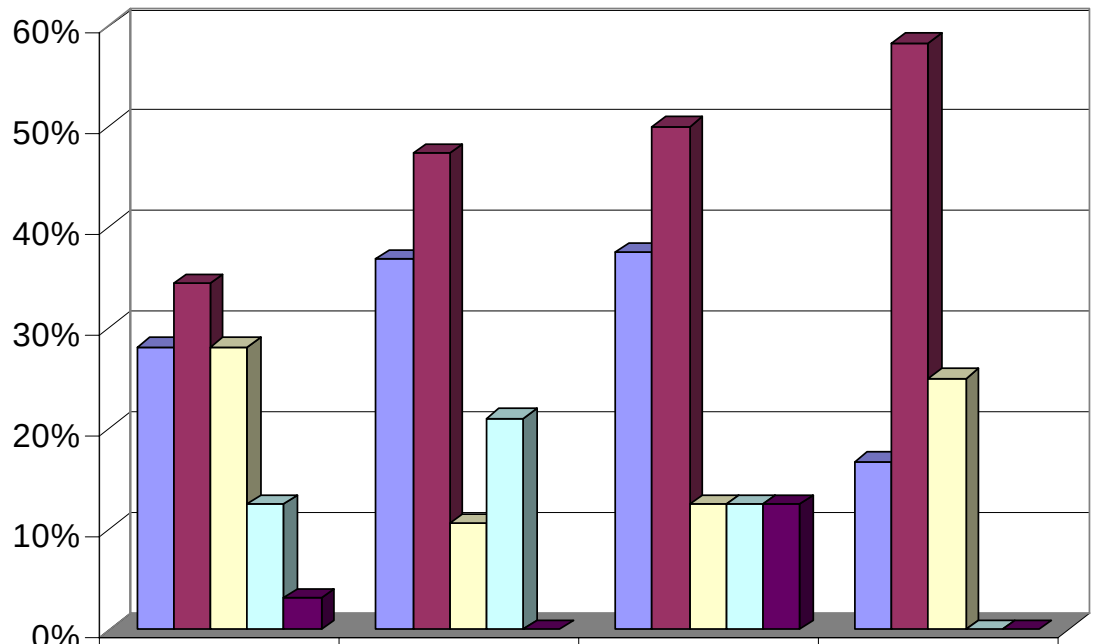
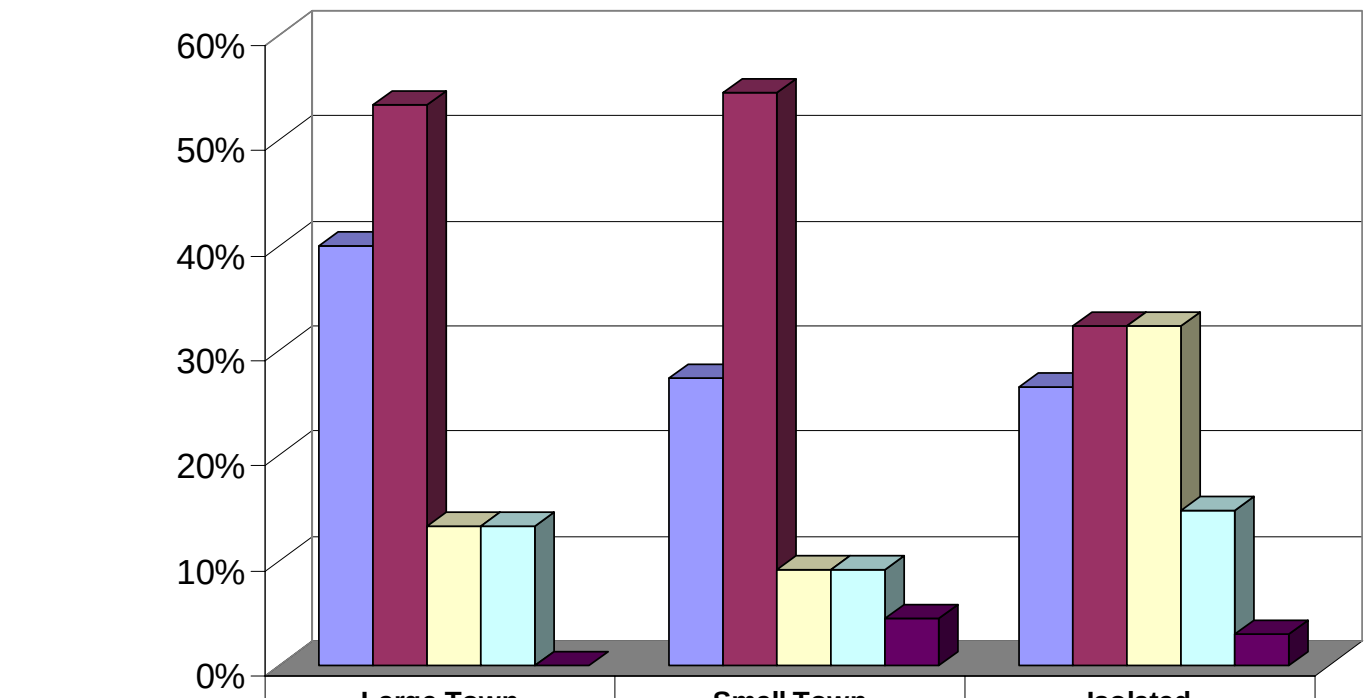
RHC Clinic Competition



	2 or less	2.1-5	>5	N/A *
None	28%	37%	38%	17%
FQHC	34%	47%	50%	58%
Other Local Providers	28%	11%	13%	25%
Hospital	13%	21%	13%	0%
Other RHCs	3%	0%	13%	0%

Clinic Size

Relationships with Competitors



	Large Town	Small Town	Isolated
Collaborative	40%	27%	26%
Good / Collegial	53%	55%	32%
No Relationship	13%	9%	32%
NA	13%	9%	15%
Difficult	0%	5%	3%

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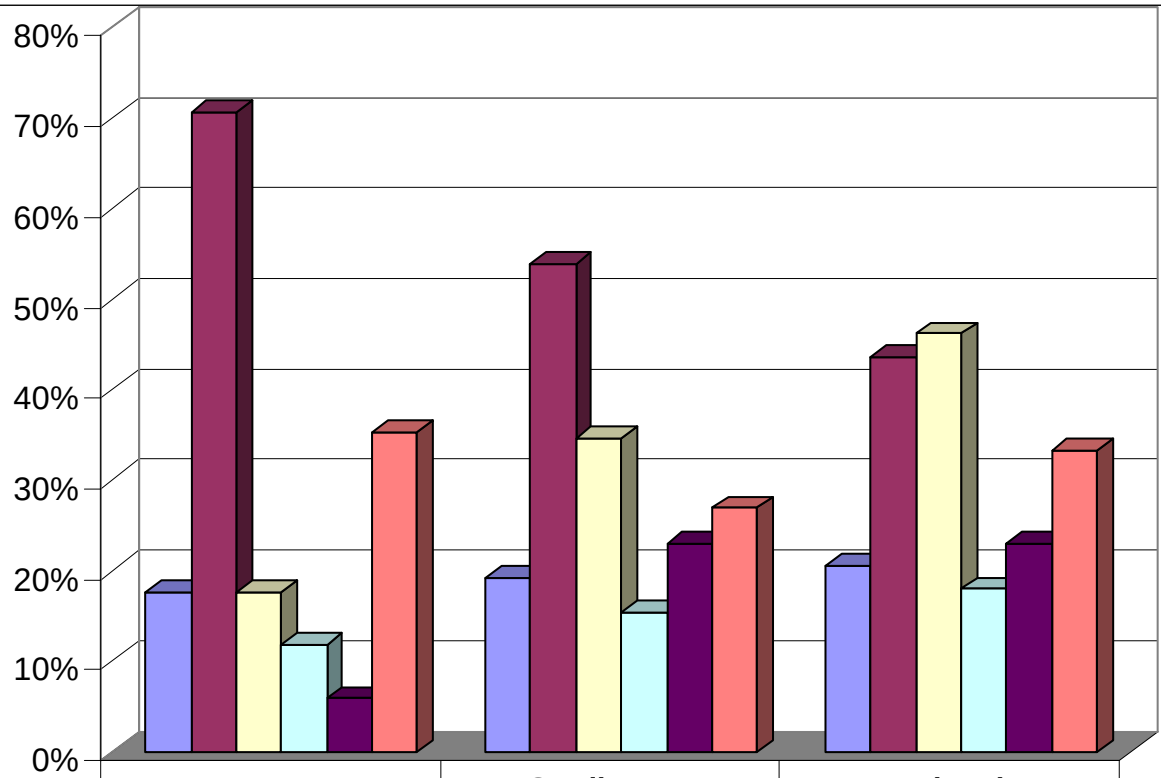
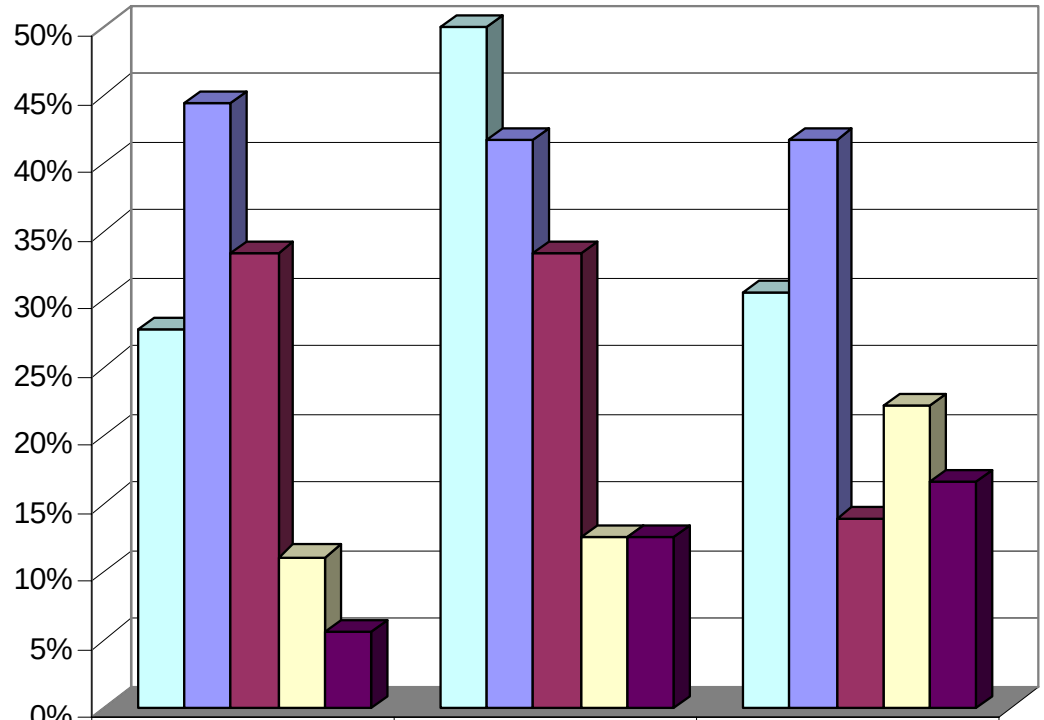
RHC Challenges



	Large Town	Small Town	Isolated
Facility Issues	18%	19%	21%
Fiscal Stability Issues	71%	54%	44%
Certification / Regulation	18%	35%	46%
Clinic Operation Issues	12%	15%	18%
Patient Health Issues	6%	23%	23%
Provider Issues	35%	27%	33%

RUCA

Benefits (besides reimbursement)



	Large Town	Small Town	Isolated
Improved Access	28%	50%	31%
Improved Quality of Care	44%	42%	42%
Increased Networking	33%	33%	14%
Access to Grants	11%	13%	22%
Reimbrusement only	6%	13%	17%

RUCA

SUMMARY

- Vital part of rural health care
- Achieving policy purpose of access for all
- RHC program makes a difference in financial performance
- If you've seen one RHC…

SUMMARY

- These are generally pretty efficient operations
- Additional revenue allows RHCs to compete for physicians
- Relatively small amounts of money have driven major financial improvement

SUMMARY

- Sliding fee scale
- RHC challenges-
  - Fiscal stability
  - provider issue
  - certification regulation
- Structure of RHCs pulls clinics to improve quality assessment and improvement

SUMMARY

- Mental health services/resources are lacking
- OB/GYN services decreasing
- In 7 of 39 counties RHCs provide the only available medical care
- Most clinicians are happy with their practices
- Small size of RHCs tend to reduce depth of infrastructure such as IT and administrative professionals

RECOMMENDATIONS

- Increase availability of, and access to billing training in order to maximize revenues.
- Support existing and future administrative simplification efforts to reduce complexity and improve efficiency (rules, regulations and formats)
- Study should be replicated from time to time
- Efforts should be made to diffuse information gained and best practices

RECOMMENDATIONS

- Explore and promote models for collaboration and organization of RHCs to improve efficiency of operations at the community, regional, and statewide levels
- Continue to use targeted subsidy as way to leverage limited tax dollars
- Continue enhanced rate
- More information needed on sliding fee scale use and best practices

QUESTIONS about the Study

- What are some questions you have as a result of what you have heard today?
- What additional conclusions about RHCs do you have as a result of what you have heard today?
- What are some recommendations you have for the future as a result of what you have heard today?

QUESTIONS

- Are there limitations to the # of new patients you are taking in the following:
- Medicare—what are the limitations?
- Medicaid—what are the limitations?
- Limitations are due to:
  - Professional Staff Capacity
  - Support Staff Capacity
  - Physical Space
  - Other
- Does the clinic have plans to address any of these limitations?
  - How

QUESTIONS

- Do you know if Emergency Department use in your area has:
  - Increased
  - Decreased
  - Is the same